CANADIAN SOCIETY FOR INTERNATIONAL HEALTH

LA SOCIÉTÉ CANADIENNE DE SANTÉ INTERNATIONALE

WORKSHOP PROCEEDINGS

April 1 - 4 , 1993

Tatamagouche Centre

Tatamagouche, Nova Scotia

Sponsored by : Canadian Society for International Health (CSIH)
Canadian University Consortium for Health in Development (CUCHID)

with the assistance of the Lester Pearson Institute, Dalhousie University

CANADIAN SOCIETY FOR INTERNATIONAL HEALTH
LA SOCIETE CANADIENNE DE SANTE INTERNATIONALE

WORKSHOP PROCEEDINGS

ADVOCATING FOR HEALTH

moving ideas to effective action

BUILDING COALITIONS

April 1 - 4 , 1993

Tatamagouche Centre

Tatamagouche, Nova Scotia

Sponsored by : Canadian Society for International Health (CSIH)
Canadian University Consortium for Health in Development (CUCHID)

with the assistance of the Lester Pearson Institute, Dalhousie University

Foreword

This is a report of *Advocating for Health — Building Coalitions: moving ideas to effective action*, a workshop hosted by the Canadian Society for International Health (CSIH) at the Tatamagouche Centre in Tatamagouche, Nova Scotia April 1-4, 1993.

Thirty-four people attended the workshop, representing all four Atlantic Provinces. These participants, from community groups, not-for-profit organizations, government departments and universities gathered to discuss advocacy and coalition building as strategies for health in development.

It was a unique, energetic group that worked together from Thursday evening until Sunday noon. They identified common challenges and learned from each others' experiences, whether their focus was on health issues in the Atlantic region, in developing countries or in a global context. People were empowered by learning how many issues we have in common, how many people are working towards a similar vision, and by the demonstrated participatory process.

Two special international guests joined the workshop and six participants had prepared case studies in advance to be discussed. They added much to the ongoing dialogue, as did the sparks of inspiration from the alternative healers who were present.

The workshop was a great success and thanks goes out from the organizing committee to all the participants, resource people and staff of the Tatamagouche Centre. Special thanks to the joint sponsors, the Canadian Society for International Health (CSIH) and the Canadian Consortium for Health in Development (CUCHID), and the Lester Pearson Institute of International Development at Dalhousie University who provided support.

The proceedings which follow were prepared by Mitchell Beer of InfoLink Consultants Inc. It never would have happened otherwise — thank you Mitchell.

The Organizing Committee
David Fletcher, Workshop Coordinator
Joan Allen-Peters
Eric Amit
Jean Arnold
Caroline Hernandez
Juanita Lechowick
Jane Oram
Lynn McIntyre
Janet Murphy-Goodridge
Marggi Pavlovski

Table of Contents

CANADIAN SOCIETY
FOR INTERNATIONAL HEALTH

LA SOCIÉTÉ CANADIENNE
DE SANTÉ INTERNATIONALE

hosts a
Workshop for Health
and Development
Practitioners in the
Atlantic Region

ADVOCATING FOR HEALTH
moving ideas to effective action
BUILDING COALITIONS

April 1 - 4, 1993
Tatamagouche Centre
Tatamagouche, Nova Scotia

... from the workshop brochure

The Canadian Society for International Health (CSIH) is an organization dedicated to making an active contribution to the evolving global understanding of health and development. This workshop is to be a forum for health and development personnel in the Atlantic Region to gather together, share experiences, and develop skills in coalition building and advocacy work.

WORKSHOP OBJECTIVES:
-to challenge participants to reconsider 'health'
-to enable participants to share & learn from others' experiences in advocacy and coalition building
-to identify some key strategies that can help us in our work
-to move towards effective action for change

GENERAL FORMAT:

This is a participatory workshop in which participants' knowledge, experience and questions will be drawn upon to form the content. The process will enable participants to take an active part in discussions about issues of concern to them.

HEALTH IN ACTION:

An integral part of the workshop will be thirty minute sessions in which 'alternative healers' from the Atlantic Region will share their practices. These experiential sessions will include topics such as massage, herbal remedies, homeopathy and holistic health.

WORKSHOP PARTICIPANTS:
Health educators, community development workers, public health professionals, nurses, doctors, activists, health promoters, holistic healers, students, health administrators, social workers, environmentalists, physiotherapists, ...
ANYONE interested in and experienced in health, development or advocacy issues in the Developing World or in Canada is welcome.

SPECIAL GUESTS:

Two special international guests have been invited to the workshop to participate in the proceedings and to share their own experiences in advocacy work and building coalitions.

Dr. Revi Narayan, Director of the Society for Community Health Awareness, Education and Research in Bangalore, India, has been very involved with advocacy work within communities, with universities and with the government. He has been instrumental in forming networks of community health groups over the last twenty years.

Dr. Carlos Coloma, a medical anthropologist from Argentina, is currently completing his PhD at the University of Montreal. He has most recently served as PAHO consultant in planning a major workshop regarding the health of indigenous peoples in the Americas.

Workshop Program

THURSDAY APRIL 1	FRIDAY APRIL 2
	8:00 Breakfast
	9:00 - 12:00 IDENTIFYING THE PROBLEM Facilitators: Linda Ross & Janet Murphy-Goodridge Vignettes depicting some of the problems with health and health care as it is commonly understood and practiced. Analysis and discussions of change strategies.
	12:30 Lunch (Main meal)
ARRIVAL AND **REGISTRATION**	1:10 - 1:40 SHARING CIRCLE 1:40 - 2:30 HEALTH IN ACTION Two concurrent sessions A: Acupuncture & herbology B: Native sweatlodge 2:45 - 5:30 SHARING CASE STUDIES Coordination: D. Fletcher Small group work of case study analysis and planning for feedback to plenary.
6:30 Dinner	6:00 Dinner
7:30 - 9:00 COMING TOGETHER Facilitators: Jane Oram & David Fletcher Introductions: getting to know one another Expectations: feedback from needs assessment and discussion Negotiation: of Workshop agenda 9:00 - 10:30 Wine and Cheese Reception	7:30 - 9:00 LEARNINGS FROM CASE STUDIES Coordination: D. Fletcher Each working group will present learnings from their case studies.

SATURDAY APRIL 3	SUNDAY APRIL 4
8:00 Breakfast	8:00 Breakfast
9:00 - 9:30 Rapporteur: Lynn McIntyre Report on synthesis of case study lessons and challenges. 9:30 - 10:00 SHARING CIRCLE 10:15 - 12:00 STRATEGIES FOR CHANGE Facilitators: Juanita Lechowick & Joan Allen Peters Small group work to plan strategies for change.	9:00 - 9:30 STRATEGIES FOR CHANGE (Conclusion) 9:30 - 10:00 SHARING CIRCLE 10:00 - 12:15 Facilitators: Jane Oram & David Fletcher Learnings Commitments Affirmations Evaluation Goodbyes
12:30 Lunch (Main meal) -Two case study presentations	12:30 Lunch (Main meal)
1:15 - 2:15 HEALTH IN ACTION Two concurrent sessions. A: Renaud Gallant - on psychic healing B: Judit Rajhathy - on environmental effects on health 2:30 - 4:15 REFLECTIONS FROM DR. RAVI NARAYAN Dr. Narayan will share some of his own experiences and lead an open forum on advocacy and coalition building for health and development. 4:30 - 5:30 STRATEGIES FOR CHANGE (Continuation)	**DEPARTURES**
6:00 Dinner	
7:30 - 9:00 PSYCHIC HEALING SESSION 9:00 - ?:?? SOCIAL EVENT - VIDEO	

Coming Together: Opening Session Identifies Common Themes

The opening session of *Advocating for Health — Building Coalitions* began with a collaborative 'scavenger hunt', in which participants got to introduce themselves as they searched for people who brought specific interests and expertise to the workshop. Group members were given 20 minutes to talk informally as they identified people who had worked in Africa or Papua-New Guinea, taken part in community-based health or environmental groups, or watched Codco the night before (one participant said she had taped it). The exercise was designed as an opportunity to share interests and expectations for the workshop, and to talk about concrete issues and concerns around health and empowerment.

David gave an overview of the three-day event, beginning with a report on the needs assessment questionnaire that participants had filled out. David said participants' autobiographical sketches, providing information on their past community experience and current areas of interest, would be circulated the following day. The needs assessment also identified the specific themes and process issues that were most important to the group. "There's a pretty general interest in all the areas," he noted, with each workshop theme emerging as a top or bottom priority for a substantial number of participants, "but as a group it kind of balances out".

Based on the survey, group members seemed most interested in planning strategies and actions for advocacy and coalition building, a priority that David said would be reflected in the analysis of case studies and ongoing networking in the course of the workshop. The theme of reconsidering the concept of 'health' received the lowest overall ranking, "but seven people, probably the second-highest total, said that was what they were most interested in," he noted. "We're going to try and find a balance and satisfy these groups of people, who are in different places in considering the different themes."

Turning to process issues, David said only 2% of participants called for an agenda that moves along quickly: 34% expressed interest in a "highly participatory process", 24% said they wanted time for reflection and free time in the course of the weekend, and another 24% were looking to take part in an in-depth analysis of the issues.

Thematic Interests
Participant Needs Assessment

Theme	1sts	6ths
Learn about advocacy	9	4
Plan strategies	6	2
Network with others	4	0
International health/ development issues	2	3
Local health and development issues	2	1
Reconsider concept of 'health'	7	9

► **Total Responses: 24**

Participants' hopes for the workshop were also reflected in their answers to the open-ended questions in the needs assessment questionnaire, David noted. Different group members expressed interest in:

- Learning about health and development issues that are relevant to a different social, political and cultural system;

- ► Building a new understanding of different modalities of health;
- ► Getting a sense of the community involved in holistic medicine, and making new contacts;
- ► Working in a community-based way to heal communities
- ► Finding new motivation to do advocacy work;
- ► Sharing insights and experiences;
- ► Building a sense of kinship with like-minded people.

Process Priorities
Participant Needs Assessment

Process Concern	%
Participatory process	34
Time for reflection	24
In-depth analysis of issues	24
Sit back, observe, listen	12
Agenda that moves quickly	2

► **Total Responses: 24**

Participants said they could contribute to the discussion by helping to identify crossovers with other workshops, sharing what they had learned in different contexts, discussing recent experience as "chief cook and bottle-washer" in a newly-formed coalition, and supporting a shift from the medical model to a social model of health. Under the heading of results, they expressed interest in taking part in a group learning experience, developing strategies for concrete, collaborative action and social change, and building enthusiasm for coalition-building across the Atlantic.

The evening session ended with introductions around the room, followed by a brief discussion of the group's process and agenda for the next 2½ days.

Identifying the Problem: Video and Vignettes Give Rise to Discussion, Analysis

Linda opened the second morning of the workshop by introducing *Closing the Gap: The Fight Against Poverty*, a video produced by OXFAM-St. John's in collaboration with two local community groups, Group Against Poverty (GAP) and Single Mothers Against Poverty. Linda said OXFAM had sought funding for the video after GAP members indicated that they wanted to make people understand what it's like to be poor.

"We all have this baggage and stereotypical attitudes about poverty," Linda said, and these assumptions are reflected in government policy — she noted that the only jobs created by the recent Newfoundland budget were for 10 welfare enforcement officers, who will each receive an annual salary of $50,000. *Closing the Gap* was produced for a general audience, and has been purchased by community groups across the country for use in elementary schools, church groups, community organizations and universities.

'Circumstances Make the Difference'

The video traced the increasing demand for food banks since 1980, and pointed out that poor people are often blamed for the impoverishment. "Oftentimes, it's circumstances which make the difference in the capabilities of a person, not the strength or the integrity or anything involved with the person," one GAP supporter said in a taped interview. "Had circumstances been different, I could be in a very different situation right now. And I think that's a challenge." Another speaker in the film noted that "looking at poverty as a deficiency is an easy way out," and is "the result of a society with unequal opportunities and inadequate safety nets." "It's never the government's fault for giving you inadequate money in the first place," another interviewee agreed.

In the course of the 20-minute video, different speakers reflected on the need to maintain a pool of unemployed or poor people in a market economy, discussed the successful introduction of a school lunch program to attack the poverty cycle in inner-city St. John's, and described the soul-destroying stress brought about by poverty. (The production made use of Tracy Chapman's musical hit, *Talking About Revolution*, while managing to save the three-word title of the song for the last seconds of the closing credits.) At least one speaker stressed that food banks are only a band-aid solution that relieves some of the obligation for decision-makers to eliminate poverty. Poverty is partly a matter of comparison and perception, but mass media ensure that differences in opportunity are obvious, and that poor children feel deprived at an early age. Part of the solution, according to a professor from Memorial University of Newfoundland, is to redefine democracy as "freedom from" poverty, oppression, squalor and hunger, rather than simply understanding it as "freedom to" do whatever one pleases.

After viewing the video, the group broke into clusters of four or five participants to answer the following questions, all of which were repeated for the vignettes later in the morning:

- What do you see as problems or impediments to health that were portrayed?
- Who are the key players in health care decision-making as seen in this scenario? What other players should be included in the decision-making process?
- Is there a way of overcoming the problems presented? What are possible strategies to overcome the problem?

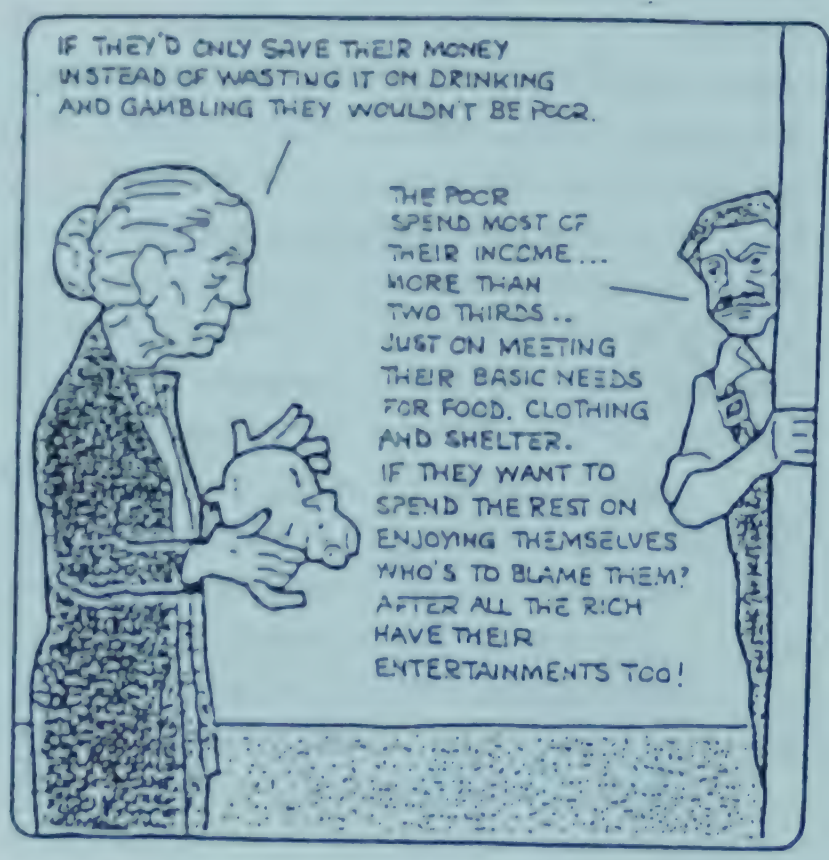
Kay began by observing that "we're all the converted in this room. There's nothing, probably, that any of us would have been surprised at." She noted that the video had presented one group of poor people, but that there are other groups that are more prone to feel powerless. In some Labrador communities, "there are generations now who have been used to living with welfare. That's all they know, and the community are trying to do something to bring young people out to see what their options are," she said. "So in a way, in some communities, poverty is expected and welfare is taken as a way of life, because the poverty has been so many generations now."

The Poverty Cycle

Caroline said her cluster group had commented on the vicious cycle of poverty. "There's no way out, no control, and no training," she said. Activists tend to hold governments responsible for combatting poverty, "but on the other hand we'd like to be free of the government so we can find our own solution." The video was a microcosm of the position of Newfoundland and the Maritimes relative to the rest of Canada in a post-industrial world, and reflected an "over-regulated system where you can't do it, because the government has a rule that says you can't". She identified the key players in the video as the women themselves and the food banks, noting that "there was little talk of what the government itself was doing".

Lynn noted that Christian theology is based on the assumptions that poverty will be with us and charity is a virtue, and expressed concern that this structure serves to stifle people's initiative. We may try to truly empathize with people living in poverty, she said, "but maybe it's a cognitive empathy that we have and not really a knowing empathy of what they live." Barbara cited Gloria Steinem's comment at a recent appearance in Halifax that "empathy is the most revolutionary emotion". A bit later in the discussion, Andrea suggested replacing the word "initiatives" with "opportunities", noting that "initiative seems to imply this notion that people are lacking initiative, that there's no motivation...Who are we and who are they? It seems to me that it's about opportunities and support."

Joan said there are few available models of effective organizing. "We don't see examples of how to change structures without pain and upheaval," she said. "Most of us solve our next problem to some extent based on our past examples of success, and I don't personally know very many examples that I can even draw on to attack this problem." She also pointed out that most of the men who were interviewed for the video were not a part of the poverty class. Debbie agreed that "the women live the experience...men were describing the experience," and "there's a lot of money being made by the people describing poverty". Linda said women have been at the forefront of GAP because our society



has a model of men as providers; when they lose their jobs they lose self-esteem, but women are still faced with the kids and have to get on with supporting the family.

Karen said the video had demonstrated that a lack of access to resources, inadequate nutrition, stress, depression, and poverty are accepted parts of our societal structure. She said the key players in attacking the problem should be the people it affects, working in a grassroot partnership with professionals and government. "We see them as key players, but in a different role," she said. "The power differential has to change." Karen said her group's strategies had focussed on building awareness and empathy, and on supporting self-help groups that "allow (poor people) to break the cycle".

Media Create Expectations

Purnima said poverty is a relative term, noting that "in Canada, we have such unrealistic expectations". Janet said this is especially true in a society where the media create children's expectations for consumer goods and feed peer pressure; later in the session, Joan pointed out that the corporate sector controls the media — "even cable television, which is supposed to be community. That's a farce."

Jane quoted Ravi's comment during the cluster discussion about the commonalities between health and poverty issues in India and Canada. Canada is seen as a rich country, Jane said, and there are certainly differences of degree. But "it's very much the same problems, the same patterns, the same ways we treat people, the same way we react to people who are poor."

One of the worst aspects of the poverty cycle is the energy drain that people experience from trying to cope with the system, "and what a loss of human resources that is," Jane said. "It really clouds the issues when something like a food bank is seen as part of the solution, instead of part of the problem....We need to be clear about what the problem is." Ravi said people in India are being urged to move into the global economy as a solution to poverty, with Canada, the U.S. and Europe held up as symbols of success. "Suddenly, I discover that this is where we're going to head. So I sense hopelessness that we're really moving in this track, but also, in a real way, some optimism...I can see a phenomenal need for coalition-building," based on similarities of experience in different countries.

Miriam said her group had looked at who was making the decisions in the GAP scenario. At first, it looked like no real decisions were being made, as if the available funds were being allocated by default. But it gradually became clear that "in the end, the decisions are being made by the elite in society," she said. "The government still feels the important thing is to remain 'competitive', so business is number one and the public sector is number two, or even lower than that."

Social Benefits = Tax Savings

The people who were interviewed for the video kept turning to the government, Miriam said, demonstrating that they felt separate from any possible solutions. The local church and at least one level of government were involved in organizing the school lunch program. But all other decisions rested "in really high echelons of society, and they're not recognizing the importance (that their decisions have) on health". One way to bridge this gap is to talk about social benefits, and the corresponding savings to the tax base: one study found that every $1 spent on early childhood intervention saved $5 in future social costs.

In response to Miriam's suggestion that poor people should be more vocal, Janet said two of the women in the video have been speaking out; Linda noted that one of them had been reported to Newfoundland's welfare police after she received $50 for appearing on a CBC radio program. Jane pointed out that provincial governments spend enormous sums of money trying to police their welfare systems, and David said there is similar waste in government monitoring of international development projects run by community groups. Juanita said she was surprised Nova Scotia was working so hard to police welfare payments, noting that social service workers in PEI had come forward in public to say there was no significant amount of cheating going on.

A participant said the GAP poster in the conference information kit had included two headlines that demonstrated health decisions by the governing elite: "93,405 companies paid no corporate tax on $27-billion profit", and "$4.4-billion helicopter deal will stand, Campbell says". Juanita said the two headlines translated to power and greed.

After a brief coffee break, the live vignettes began. The first of the two vignettes was a six-part skit tracing the efforts of Nettlé Ltd., a (more or less) hypothetical multinational company, to market its infant formula in Newfoundland and Papua New Guinea.

The first scene of the skit showed the president of Nettlé, the Atlantic sales rep and the Third World rep discussing sales strategy. The president expressed concern that a "fringe group" was "trying to discredit us in favour of breastfeeding," and warned that breastfeeding must not be allowed to eat into the company's profits. The Atlantic rep stated that only 40% of Newfoundland women were breastfeeding their babies, Nettlé's was a household name, and the purchasing officer at 'Graft Maternity Hospital' was a relative. "Getting the babies hooked on our product will be no problem," the rep said. The Third World rep was also optimistic, based on the company's sales experience in the Philippines. "A few dollars thrown here and there goes a long way," she said, and free samples are a great way to draw in new consumers.

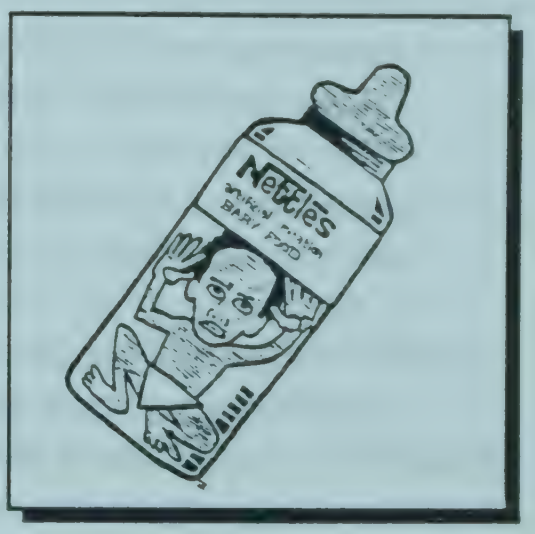
'Almost As Safe'

Scenes 2 and 3 took place in St. John's, beginning with a discussion in the Atlantic rep's suite at the sumptuous Five Star Hotel. The rep met with Graft Maternity board members to propose a "mutually beneficial" contract, in which Nettlé would pay the hospital $2 million to exclusively promote its formula to all new parents. The company also offered to provide educational funding, the rep said, "because we stress very much the benefits of partnership." The chair of the hospital board said the institution was committed to breastfeeding, but was prepared to be creative in searching for new revenue sources in an era of government cutbacks. The hospital's main concern had to do with negative publicity, but the sales rep pointed out that Nettlé already held 50% of the Newfoundland market. "Our formula is the safest on the market, and almost as safe as breastmilk." In the third scene, a hospital nurse went to extraordinary ends to try and force a bottle of formula on the parents of a new infant, even though the mother was committed to exclusively breastfeeding the baby for the first six months.

The situation was different in Papua New Guinea, when the Third World sales rep met with the Minister of Health and a local public health official to present the company's $2-million offer in Scene 4. "In exchange for that, all we want is that for 15 years you will guarantee that our baby formula will be in all your hospitals," she said. The rep stressed that Papua New Guinea could use the money, and offered to throw in pens and notepads, gift packs for the babies, and

extra funding for health officials who wanted to attend conferences. "Two million dollars goes a long way," the rep said, but the Health Minister was not impressed. He said the rep had made a serious error bringing the Nettlé proposal to Papua New Guinea, noting that his country had officially adopted the World Health Organization convention prohibiting infant formula advertising and distribution of free samples. The $2 million was appealing, he said, "but we're not prepared to jeopardize our children's health and our society." Noting that Nettlé was also on record as supporting breastfeeding, the Minister asked the rep if she would like to visit a village clinic the next day; she responded that her schedule was simply too tight.

The rep's next stop was in a clinic in southern Uganda, where she was scheduled to meet the company's local sales executive. In Scene 5, it became clear that Nettlé's products were being promoted aggressively through local hospitals, and were available in all the stores. Scene 6 showed a local doctor examining a baby who had lost weight and was failing to thrive; after determining that the mother was using Nettlé infant formula in unsafe conditions, he advised her to get rid of the bottle and breastfeed instead. Toward the end of the sketch, the doctor noted that many physicians had been encouraging women to feed their babies formula instead of breastfeeding. "They're criminals," the mother responded.



A Difficult Offer to Refuse

In the discussion that followed the vignette, participants identified the following problems and impediments to health:

- The opportunity for a company to take advantage of an underfunded health system, making offers that a hospital board would find difficult to refuse;
- Manipulation;
- General acceptance of unethical marketing practices, with no sense on the part of the marketers that they were doing anything wrong;
- Profit motive for multinational corporations;
- Lack of public knowledge of the real benefits of breastmilk compared to formula;
- Acceptance of the notion that infant formula represents "progress";
- Unwillingness to recognize cultures and traditions;
- The assumption that profitability is the ultimate goal, reflected in the concern that a community group would "eat into" the company's profit;
- Professional misinformation, fostered by a lack of orientation to values or ethics in professional education;
- A lack of caring on the part of the "whole corporate agenda", reflected in a willingness to take advantage of marginalized people;
- Sexism, racism and paternalism;
- Transfer of control over health care from local communities and established culture to a superimposed system that people feel powerless to oppose.

Linda noted that the group had come up with similar concerns and language in response to the GAP video and the infant formula vignette. When she asked participants to identify the key players in the sketch, they listed the following:

- The corporate sector;
- Hospital boards;
- Hospital staff and professionals;
- Mothers;
- Babies;
- Father and mothers-in-law;
- Marketers trained in a competitive model, who think they're just doing their job;
- Benefits attached to the company's profit motive that forced the hospitals to make a choice;
- Government cutbacks as an underlying factor forcing institutions to consider unethical or undesirable offers.

A Health Worker's Dilemma

A participant noted that the situation portrayed in the vignette presents a serious dilemma for health workers. "In real life, there are often good programs attached to these things. If you're a worker in that hospital this is an opportunity to get something done." Hospital representatives often accept the offer, telling themselves that people are already using infant formula, anyway. Janet noted that Papua New Guinea is one of the few countries that have made the WHO code mandatory, so that formula is only available by prescription. There is virtually universal support for breastfeeding mothers, because their own mothers and aunts did it themselves. Juanita said more work is needed to encourage countries to legislate the code, and Lynn pointed out that "marginal fringe groups" have been unable to lobby effectively and get access to key decisions. "We never have the resources to be able to put out the (promotional materials) that are eye-catching, that are appealing," Linda added. Janet said the Canada-U.S. free trade deal prevents legislators in Ottawa from adopting the WHO code.

Lynn also noted that governments' contracts with their corporate partners are cast in stone and virtually impossible to break, even though "they're constantly breaking contracts with people". Ravi said multinationals believe they have enough money to overturn any decision, so that they aren't really bothered by legislation. "They might even support the legislation for all you know, and build up their public image," then lobby for changes at a later date. Andrea noted that corporations won't voluntarily stop using their power, but suggested that community economic development and community-based social development "may in the long term make people less vulnerable" to unscrupulous marketing tactics.

Chipping Away at Self-Esteem

Jane pointed out that the nurse in Scene 3 had not convinced the couple to use the bottle, but "it's that kind of chipping away at your resolve and your self-esteem," she said. "I think that happens a lot to women who are breastfeeding," particularly when they visit a doctor with a routine problem. Janet noted that we live in a bottle-feeding culture, and Jane agreed that many mothers drop off within three to six months.

Sheila said the scenario had lacked one key player — the historian who could go back to a meeting 24 years ago, when she could remember developing the same set of lists. "It's like a flashback," she said. "It's incredible." Andrea agreed that she couldn't see what had changed since the Nestlé boycott in the late 1970s and early 1980s. Ravi stressed the importance of "bringing the babies back in" as a means of inspiring and energizing the movement. Breastfeeding is partly about bonding, and bonding is partly about women and men wanting to be good mothers and fathers, so focussing on the babies "may give us the energy to make difficult choices that might help the next generation". He said the mental and social benefits of breastfeeding should receive far greater emphasis, particularly in professional education; Purnima agreed that values and ethics should be a very strong component in all health curricula. Joan said positions in community health should be restricted to people who were breastfed as infants.

Debbie challenged the idea that nothing has changed, noting that "the biggest thing that changes is people's thinking". She said she struggles with the question of how we can create images of a different future that don't need catastrophes, violence or death to get us there, even though it's a future we may never have seen before. We're conditioned not to notice small changes, she said, so we have to be careful to look for them and learn that it's okay to feel good about our incremental successes. Feng said the pace of change is faster in developing countries, where dramatic shifts can occur in one or two years. Joan pointed out that many health practitioners are still working within a framework that requires quantitative data, but ignores the qualitative changes that often reflect initial efforts in primary health care and community development. Andrea agreed that "there's a shift in values that's necessary, because it's going to be very difficult for us to justify and describe our work and show any major change in numbers."

Feng returned to the discussion to cultural concerns, noting that breastfeeding is just one example of the loss of healing traditions. He said traditional medicine is in danger of being lost in China, due to the invasion of western approaches; this would translate into an immeasurable loss for all of humankind. Ravi pointed out that it is often more difficult to control domestic industries, even if their practices are similar or identical to those of multinationals — if anything, the home-grown firms have closer connections to the government in power.

'Just a Part of Motherhood'

Ravi also pointed to a fundamental cultural difference that has supported breastfeeding in India, at least until now: "The breast is not a sex symbol," he said. "It's just a part of motherhood." Women in India have traditionally had no trouble breastfeeding in public because "it's the most natural thing to do. There is nothing sexual about it. But this is changing now, because all the values that have prevented mothers from breastfeeding (in North America) and put them into awkward situations are coming into our values, because of television." Janet recalled a similar situation in Papua New Guinea, where women performing a traditional dance were urged to wear brassieres by missionaries.

In the final vignette, entitled *The Magnetic Resonance Imaging Caper*, a participant played a provincial Minister of Health appearing before an audience of physicians, university administrators and community health representatives (CHRs) to discuss health care priorities. The Minister expressed strong rhetorical support for prevention and primary health care, but gradually admitted that the "very important services of community health" were only receiving 7.6% of the provincial

health care budget, compared to 67% for hospitals. The Minister held her ground against criticism from a variety of community representatives, claiming that a blue-ribbon panel on health care costs had consulted the public by travelling the province and telling people what services they needed. When an old friend in the audience challenged the Minister to support an extension of a successful school lunch service, she said community volunteers should run the program. The only support for provincial policy came from a physician in the audience who had successfully lobbied for a new MRI scanner worth $300,000 — just over two-thirds of the total budget allotted for community health.

In the discussion that followed, participants identified the following problems with the scenario:

- Hypocrisy on the part of a Minister who "spouted the rhetoric of primary health care and public participation" but was "just not walking the talk";
- Lack of public awareness, making it possible for politicians to speak the language of community health without providing tangible support;
- A very real concern on the part of health workers that they will be penalized if they speak out about gaps or inefficiencies in the health system;
- A "departmental shuffle", in which government officials toss responsibility for community problems back and forth among agencies and jurisdictions;
- The medical establishment, represented by the physician who lobbied successfully for the MRI;
- Four-year terms of office that discourage or prevent governments from taking a long-range view in areas like community health, while limiting their accountability for mistaken priorities that will lead to problems in years to come;
- Consultation processes that gather public input, but allow no opportunity for stakeholders to take part in actual decision-making;
- A failure to distinguish between community participation and social marketing, so that a consultative panel is essentially mandated to tell people what they want and what to do;
- Reliance on hospital administrators, businesspeople, and other political appointees to staff boards of inquiry;
- The accepted role of hospital facilities in bolstering community pride;
- The inclination of conventional health practitioners and politicians to give technology priority over primary health care, to fund an acute care centre over a women's shelter;
- Media programming that still gives all the "glamour and glory to acute care settings".

A participant said this was the only case in which the people had emerged as a key player. In contrast to the new mothers in the first vignette, members of the university audience could place their concerns in the context of a broader policy issue. "There's an awareness thing that is very different from educating the public." In this context, the participant said the process of participatory action research is political by definition.

A group member said the political clout of the physician in the scenario demonstrated the need for capacity-building and leadership development among nurses and other marginalized groups in the health system. Another speaker noted that First Nations face a similar power differential in their negotiations with the federal government, where four or five community represen-

tatives come up against a much larger team of negotiators, consultants and lawyers. The situation is supposed to be an equal discussion around the table, but it's not.

Commitment Without Resources

A participant noted the contradiction between an ideal definition of health and the small proportion of the health bureaucracy devoted to primary health care and community health. All the documentation calls for greater integration and multi-disciplinary work, but the Minister's own statistics demonstrated the gap between theory and reality. A second problem has to do with the millions of institutions, such as religious organizations, that have a stake in using health services to promote themselves world-wide. It was also noted that the "rhetoric of participation" may be enough to satisfy public demands for greater input into a more community-based system, "but on the other hand there's a negation of the sharing of power, and therefore a vacuum is created". In this light, it is impossible to devise strategies around community health development that exclude a process of dialogue, understanding and exchange.

A group member expressed serious concern that community health and volunteer services are being treated as "the wastebaskets where you put difficult problems, with no resources and no legitimacy". Funding is never permanent, and services are often supported under the heading of demonstration projects. Primary health care is considered a demonstration project in Nova Scotia, but "maybe what they should do is hire 40, 50, 60 community development workers from the communities themselves, and give them the resources to really do something." Such a program would truly provide a basis for primary health care, "rather than dopey little buildings getting renamed". If the province were to invest in real community infrastructure, the group member said, "you might actually get the kind of synergy you're looking for". But governments are now saying they have no role in funding advocacy groups.

The next speaker suggested that government programs "allow us to believe they're really trying to help us along," when the real effect is to force non-profit organizations into more cautious strategies. Rather than attempting to deliver complementary services, she said community health practitioners should accentuate the differences that add up to an alternative approach to health. The speaker also noted that most positions on government boards and commissions are patronage appointments, so that regulators and reviewers can be expected to support the government line. "It's really quite undermining, because every time you complain, the government says, 'well, we have this committee.'"

Ravi noted that the MRI case has a parallel in India, where multinational companies pay professionals a commission every time they refer a client for a high-tech intervention. If a doctor knows that a holiday overseas will cost 5,000 rupees, he or she knows that 25 CT scans will cover the cost.

To conclude the session, Linda invited participants to join her in summarizing the common themes that had emerged from the video and the two vignettes. She said issues of powerlessness, victimization, and a lack of ethics had been evident in all three cases, and noted that the key players were always power brokers, business and the media. Community voices were consistently absent from the process. The strategy "seemed to be, to some degree, to take what was working against us and get it to work in our favour." Participants said the session had underscored the

need to change attitudes, address our own apparent powerlessness by breaking the system open, and get more physicians involved and onside with community health.

A couple of serious concerns arose. Lynn pointed out that it's a luxury to assume people will get the power back if they're given a voice: "In other societies, they get shot for that kind of activity," she said. "I think that's our false belief in our own paradigm." People in Canada may be able to take power for themselves, but "that may not in any way change the fundamental structures". Jane also noted that community decision-making may not always go hand in hand with primary health care — people in Parrsboro want to use their health resources for the hospital.

Andrea said our philosophies are often pretty vague, partly because it takes so much energy to figure out what's blocking us. "I think our imaginations are really truncated and impoverished by the situations we're working in, and by a real need to bust out of those corrals that we're in," she said, adding that it's appropriate for coalitions to refuse to take part in certain government consultations "unless we have some influence over the decision that comes out of it".

Carlos said we have to be clear about whether our strategies are designed to patch things up or transform the structures of society. Jane said it's a lot harder to talk about problems than strategies, and said she hoped the group would have time to critically reflect on strategies for reform versus transformation.

Health in Action:
Holistic Work Adds to Richness of Workshop Experience

The health in action workshops were set up as informal, participatory sessions to introduce participants to healing concepts that are unfamiliar in western cultures. The experience left several participants looking forward to the opportunity to debrief on the experience and evaluate the effectiveness of holistic medicine more closely.

On Friday weather conditions prevented two of the resource people to attend the workshop so four participants volunteered to share their own knowledge and experiences of complimentary medicine. Sheila and Feng agreed to lead a discussion on acupuncture and Chinese herbal medicine, and David and Juanita answered questions after showing a video profile of a healer at the Peguis First Nation in Manitoba.

In the first discussion group Sheila and Feng shared their experience with acupuncture. Sheila described her training in the techniques of acupuncture, and explained that she only had a limited knowledge and was not very familiar with the underlying philosophy. As a physiotherapist, she talked about how acupuncture has been very useful to her for certain things. Feng added that there are different types of Chinese medicine. He described one, of which acupuncture is a part, which is based on the concept of 'chi', a form of energy that moves through the body in channels and another that is based on a balance of the five elements. Feng later described some of his knowledge of Chinese herbal medicine based on some of the experience gained from his father a western trained doctor who turned to more traditional medicine in his later years. These were both fascinating discussions.

In the second group a short video was shown featuring Mide Megwan and Cathy Bird, two Native healers from Manitoba, who described their area, Matooto Lake, as a natural healing centre. They provided much insight into the spirituality of Native healing. They described the interconnectedness of body, mind and spirit in Native traditions and were shown guiding a group of health professionals through a sweat lodge ceremony. David and Juanita, who had both participated in a visit to Matooto Lake, described their experiences and answered questions from the group. A number of participants commented on the similarity between the holistic ideas expressed on the video with what they knew of other cultures around the world still connected with the land.

On Saturday participants chose between a presentation on environmental health by Judit Rajhathy of Dartmouth, N.S. and a discussion about psychic healing by Renaud Gallant of Notre dame du Portage, Que. Renaud's session was repeated Saturday evening by popular demand and included two demonstrations.

Judit summarized her workshop in a brief interview for the proceedings Sunday morning. "I guess what I'd want people to take away from the session is just to be more conscious and aware that their immediate environment is directly affecting their well-being, whether it's spiritual, mental or physical, that whatever people do daily like breathing, eating and drinking has a direct effect on their health." She said the session had also emphasized "the whole idea of taking responsibility, looking for causes, taking action, changing lifestyle. Basically, I feel my role is to give out information that's not often presented, because I'm not backed by any interest groups — Kraft Food is definitely not my sponsor, and there's no profit to be made in people changing their lifestyle."

"In my practice, I see that it's those changes that mean pretty well everything," Judit said. "I'm seeing people who have gone through the medical model and have not received relief, so obviously there are a lot of cracks in dietetics as well as the medical model. One of the things that I think is integral to a holistic practice is that I believe people's experience — what they tell me is true for them, and I take all my clues from that truth. In other words, I want a book from them, and I actually read it. The more information people give me, the better chance I have of figuring out what the need to change in their diet or lifestyle, so it's very important to trust people's experience and not negate it." She said women, in particular, have a great deal of difficulty getting medical model practitioners to take their experience seriously.

Judit said it is sometimes important to give a client an affirming touch or a hug at the end of a session. "Although I'm working mainly with the physical in my practice, I certainly honour and respect the spiritual aspect," she explained. "So by hugging them, I feel I'm closening the connection, so that they are more inspired to leave my office and do what they need to do. That's sorely lacking in the medical system...it's great that people are good clinically, but you have to have that element of humanity."

Renaud's sessions gave participants a snapshot of the potential power of psychic healing, and convinced a number of skeptics that the approach has a place in a community-based model of health. Participants and organizers were amazed that Renaud and his colleagues even reached the workshop, after driving day and night through an unexpected storm and reaching Sackville, New Brunswick at 4:00 a.m. Saturday.

Feng was the first participant to come forward in the Saturday evening demonstration. "I first felt a kind of pulse, or something going through my foot — a very strong, different kind of feeling — and then I felt the bones in my feet moving and being pushed," he later recalled. "Then, when he turned me into another position, I felt a very strange period of spasm. After he did a little bit of manipulation, the spasm quickly disappeared. It became very, very comfortable."

Renaud treated a liver problem that Feng had had for some time, and "I just immediately afterwards felt very comfortable," Feng said. "It's released, and I had a very nice sleep last night...The amazing point is that he found out all of my existing problems that I knew, which was also true for every other person who asked him for an opinion of a problem.I Every one of them was true. This kind of practice has a long history in China," but "I'm amazed that as a Chinese, I'm here to receive my personal treatment in Canada."

Even if we don't understand holistic healing in scientific terms, Feng pointed out that it's been working for thousands of years. "Some day we will know something more, but the best way and the right attitude is not to simply say 'no, I don't believe it'. I think people should be open-minded, and just learn and observe and try to study...Reality is reality, and I don't think you should wait until you have a terminal illness to look for a cure."

Sheila echoed Feng's fascination with the experience. "I felt I was open-minded, and yet pleasantly surprised," she said Sunday morning. "I didn't expect to be surprised by anything, but I was. And I was glad that the surprise made sense to me, and that he was able to make sense of my problems without actually knowing anything about me beforehand. I really thought I was going to have to tell him what my symptoms were. What surprised me was that he didn't ask me any questions, came up with a diagnosis that I knew, and gave me more information than the medical profession had ever given me. Based on my medical knowledge, it made sense to me."

Ideas in Process . . .
Workshop Organization Reflects Democratic Decision Style

Evidence of flexibility and participation were identified throughout this workshop. The organizing committee consistently asked for input and feedback, allowed for group decision making and fine tuned the programme to meet emerging participant interests.

A request was made on the opening night of the workshop for volunteers for two committees, one to manage "Energizers and Socializers" the other to facilitate "Observations and Evaluations".

The volunteer Energizers, Sheila and Miriam, sprinkled short exercises and games, such as 'pass-catch', liberally throughout the workshop. These 'activity breaks' brought much laughter and energy to the event. They also organized Saturday's 'social' based on participants suggestions — dancing in one room and a video in another.

The second committee, Jane and Andrea, observed the overall process of the workshop, made some suggestions and recommendations as events unfolded and contributed much to the evaluation activities.

Plenary discussions on the first afternoon reflected the strong commitment to democratic process that infused the entire event. David introduced a speaking circle, a facilitation tool designed to give every participant the opportunity to raise positive or negative points about the progress of the event. An object was passed around the group twice and each participant had the opportunity to talk whenever they held the object. The technique was used periodically throughout the workshop. David clarified that the speaking circle as it was being used was different from Aboriginal spiritual ceremonies involving sacred sticks or stones, and was not intended to co-opt the traditions of another culture. These sharing circles were a formative form of evaluation, allowed an opportunity for reflection and helped people to speak from their hearts and not just their heads.

Standards were jointly set the opening night about punctuality for sessions, and it was agreed that yellow and red cards would be used as time-signals for individuals and groups. A yellow card could be given discretely as a warning that people should wrap up what they were doing within a couple minutes — a red card that time was up and it was necessary to move on.

Weather conditions were terrible Friday afternoon and evening and could have wrecked havoc on an rigid program — seven participants and three of the resource people could not fight through the ice and snow to attend.

Four participants volunteered to stand in for the missing 'health in action' resource people. This included fascinating discussions about acupuncture, Chinese herbology and Native sweat lodges.

One case study had to be cancelled because the resource person did not arrive and two other case studies had to be cancelled because of the smaller number of participants. Participants signed up for the case study of their choice and only four were studied initially. Due to much interest the final two case studies were presented at lunchtime on Saturday.

This spirit of flexibility, cooperation, adaptability and active participation on the part of all participants went a long way in making the workshop a success.

Case Studies

Following the first set of Health in Action sessions, there was a brief plenary to introduce the case studies. David asked participants to sign up for the breakout group of their choice, and explained that each group would follow a process in which:

- The author of the case study gives a brief presentation, then leaves the group to discuss the case in his/her absence;
- The group does some analysis and answers a set of questions about the case;
- The presenter comes back when invited, to answer clarifying questions or address specific issues;
- The group continues its analysis and begins planning its report back to the evening plenary.

After brief discussion of the process, participants broke into four groups to consider the case studies prepared by Kim, Carlos, Shirley and Lynn. gkisedtanamooqk of the WABANAKI Cultural Resource Centre was unable to attend the workshop to present his case study, and there were not enough participants to form six groups and discuss all the remaining studies. Instead, the cases prepared by Purnima and Kay were discussed in informal groups the following day. Groups worked on the case studies for the rest of the afternoon.

The Case Studies: Participants Review Options for Action

The Friday evening session heard reports on the four case studies that participants had reviewed during the afternoon.

Nova Scotia People With AIDS Coalition, Black Outreach Project — Kim Bernard

Isaac said the group reviewing Kim's case study had identified the core problem as "yet another manifestation of institutionalized racism." The combination of HIV/AIDS education and racism "tends to isolate or marginalize or segregate communities," he said, and this case affects a community that already feels it has been set apart from the mainstream.

A related problem is the widely-held belief that the human immunodeficiency virus originated in Africa, which has led the black community to distance itself from AIDS education and prevention efforts. "The black community sees itself as a victim of racism, so whenever there is any attempt to come into the community to deal with an issue like AIDS, they don't see the urgency," Isaac said. This sense of alienation was reinforced when the Canadian Red Cross refused to take blood donations from a group of black Nigerian students, even though a screening procedure had been established and clear guidelines were in place.

The group concluded that Kim's options and alternatives included:

- Seeking new resources for education and training, to reduce her own isolation as coordinator of the Black Outreach Project;
- Using video resources to broaden the Project's education activities and get youth involved;
- Recognizing that issues of racism and cross-cultural contact should not be left for one community, project or coordinator to solve. Front-line AIDS organizations should share responsibility for dispelling the myth about HIV/AIDS and Africa, and the groups in the Atlantic and Nova Scotia should take ownership of the racism issue and find ways of addressing it. This effort would likely create the political will to allocate sufficient resources to solve the problem.

Group members shied away from identifying a preferred option because all three were inter-related. "The real emphasis was to be able to provide a better and lasting solution," Isaac explained. "We should go to the basic problem, which is racism, and recognize that as a phenomenon in society that is having an impact, even on AIDS education."

The group looked at the cost of the various options and noted that Kim could do a lot with the resources already available to her. "It might be necessary to seek additional funding," Isaac said. "But, again, it will become easier if the whole AIDS education organization makes it their agenda, rather than (leaving it to) one of the black organizations in Nova Scotia."

Kim said she appreciated the group's feedback and described the case study process as "a useful tool in terms of looking at some of the solutions that would be useful to meet your needs....I'm telling you, it really helped me." She said most people haven't realized the implications of AIDS and racism, and noted that she feels isolated in her day-to-day work.

Jane noted that the People With AIDS Coalition had originally sought funding for a black outreach program because it wanted to reach the community. But now, whenever issues arise related to racism, "that piece goes to Kim. It doesn't then have the broad ownership" within the Coalition. "Kim was kind of marginalized to do this piece of work and take care of all the issues

dealing with black Nova Scotians," Jane said, suggesting that the process had been "very parallel to the segregation that black communities experience". Organizations need staff who can make the connections and do the work on issues like AIDS and racism, she concluded, "but you do need that broader ownership of the problem".

Carlos indicated that he might be able to help Kim build links with AIDS resource groups in Montreal; Kim said she would get in touch before travelling to Montreal in May.

Lynn said the case study demonstrated that AIDS among black Nova Scotians is a small problem within a broader problem of racism. She suggested that the smaller problem might be a useful starting point for combatting the bigger one. "The gay community has actually been able to become transformed, and has gone the whole gamut of the difficulties they had when AIDS came to that community," she said. Terrible diseases have a way of bringing people together, and "maybe that's one of the ways of coming to some common ground and overcoming some of the racism and the barriers that pervade. Everybody is getting slammed with this disease, for all kinds of stereotypes." People have already stopped trying to identify the 'innocent victims' of the HIV epidemic, Lynn said, so there may be some potential to reframe HIV/AIDS as a tool to fight racism. Kim noted that HIV/AIDS and racism are two big issues that nobody wants to talk about. "So when you put that combination together, you're talking about a race of people who are experiencing both...that's something pretty serious."

Labrador Inuit Health Commission: Management of Non-Insured Health Benefits — Shirley Lyall

Kay traced the evolution of the case, noting that LIHC had taken over management of non-insured health benefits (NIHB) before Health and Welfare Canada decided to contract the service out to Blue Cross. The Labrador Inuit successfully lobbied to retain control of the service, "however it obviously could be taken away at any time that the government chose to do that," Kay said.

Based on the case, it appeared that the real problem was a communication gap between LIHC and the Medical Services Branch of Health and Welfare, Kay said. But from its analysis of the information, Kay said the group concluded there was a much wider issue, "related to the lack of real control by the LIHC over their health resources. We thought this was partly due to cross-cultural conflict, so therefore there was the need to support the solutions the community had come up with, by negotiating a relationship with government that operationalized the plan they had developed."

The group looked at solutions in the context of the wider community, "and felt that maybe the first step would be to define what was in fact the Inuit community's view of health, and what was their vision of health care," Kay said. When Shirley came back to the group, she indicated that a health plan was already in place, so participants focussed on how to use an existing plan as a starting point for influencing government. Discussion focussed on the need to demonstrate broad community ownership of the plan, then take the political step of advocating for control of resources.

There are pros and cons to this strategy, Kay said. The obvious advantage would be the opportunity for LIHC to take control of the community's health services and serve as a role model for mobilization and empowerment for other Inuit groups. Local control would not cost much more than the Blue Cross contract, and would offer "the benefits of community development and

generally benefitting the health of the community". The disadvantage is that the Labrador Inuit "could lose what has probably been a very polite, cordial relationship that they've had with the Grenfell Regional Health Services and the provincial and federal governments." Fracturing that relationship could have an impact on land claim negotiations, and might put the Commission and the Labrador Inuit Association in the position of assuming a role that is very similar to government control.

Shirley responded to the group's report by stating that she had erred in preparing the case, by assuming that people knew more about the Inuit than they do. The result was that people didn't seem to get the intended message from the case study. "We ended up talking about politics rather than the administration of non-insured health benefits," she said.

David said it's true that community health development "often comes down to politics as a bottom line, and that's such a complicated thing". Juanita said Shirley had tried to explain the Inuit perspective on the issue during the group discussion, "but we were a little bit thick". Kay said the group had wanted the Inuit "to go away and be the leaders in that process," to which Shirley responded that "we can all dream on, I guess."

Ravi said the case had taught him that you can't generalize about Aboriginal peoples, or even about the Inuit. "We sometimes have to see subgroups, and our solutions have to be creative to the needs of those subgroups. Broader solutions are a bit too broad, sometimes," he said. Shirley said her community had tried to tell the government that they're different, and that LIHC programs are based on consultation with the people. "We want what we want," she stressed. "If they took the non-insured health benefits administration away from us, it's just another case of government dictating, even if they're giving it to Blue Cross rather than the people themselves."

Jane told Shirley that the case seemed to show that "you were playing a game in which you had no role in setting the rules. Medical Services established the parameters, and it sounds like you did a good job" of promoting community-based service delivery with sound developmental work. Shirley responded that "we're proud of what we've done, and we want to keep it that way. We want to get that across — don't fix something that's not broke. Leave it alone. We're doing fine."

Health and Welfare Canada "is generalizing us as just another Native group," Shirley continued. "As a government department, they probably just overlooked that each group is different, and each group wants different things. This is not for every Native group in Canada...but we want to take it on. We want to keep it, and that's what we're trying to say to Medical Services Branch." One frustrating part of the problem is that "we've got to tell our story over and over and over, because there's such a big turnover in government all the time."

Jane linked the discussion to the broader question of advocacy and coalition-building. "When I hear a case study like that, if you're a community person and you're involved in an issues, there's a dance between staying really focussed on your community's needs and the extent to which you join with someone else in a common struggle." Euro-Canadians tend to think of First Nations as a single culture, "but it's a patchwork of cultures that are very, very different."

David noted that we tend to talk about geographic and cultural communities, but noted that there are communities of interest, too. Cultural groups are interested in greater control of community health, and the voluntary community has generally supported that, "but a lot of the funding agencies and the other people all over the world are moving in the direction of more

privatization, and taking money away from the non-government and voluntary organizations," he said. "They want a business organization that can come in, take things on, and they're big, strong and reliable." Shirley said LIHC is still trying to make federal officials understand that the Labrador program is already up and running, so bringing in Blue Cross "is only to go backwards and will cost the government a lot more money than if they leave it alone. I think there's an attitude, too, that Native people will rely on government," but "we don't need the government to administer the program for us. We can do it ourselves," and "we take pride in that."

So Your NGO Wants To Do Advocacy? — Lynn McIntyre

Sheila recapped the history of the non-government organization (NGO) as presented in Lynn's case study, and traced the formation of three board-level committees to deal with education, advocacy and communication. Responsibility for the advocacy committee "was left in the hands of one lone Canadian," with no clear definition of the work to be done. Based on Kim's experience, Sheila said, "we can advise this person to get help before you even get started."

The gap in the organization's definition of advocacy reflected a change in direction at the NGO's head office, and left Lynn with a choice between setting the direction or going back to the board for more direction. Sheila said the group had agreed that "this person has been unfairly left, and needs help." In the course of the discussion, other group members observed that:

- Committee chairs were in the position of trying to get things done, even though they were disconnected from the organization's head office in Ottawa;
- The board has not been clear enough about program objectives, and has not established a clear vision as the basis for specific committee mandates;
- If the board asks Lynn to go out and create her own mandate, the best approach might be to look at successful models developed by organizations like Frontier College, where authority is vested primarily in clients and field staff;
- Because of its combination of interest area and professional membership, the NGO should be looking at ways of identifying and consulting non-professional stakeholders in other countries;
- With only two board meetings and a couple of conference calls each year, "there is a great deal of isolation" for NGO board members who are located outside Ottawa or Upper Canada. One solution for committee heads might be to set up an informal support group to serve as a local sounding board for NGO issues.

It was noted that other NGO board members are looking to the committee heads for direction, but they want the process to be complete in three months. Barbara said the whole process seemed quite abstract. "There's not enough connection with the ground, in some way, and the ground is actually in countries where programs are being or might be done." Ravi said everyone wants to be involved in advocacy and networking, "but actually advocacy and networking have to be around an issue." He noted that many NGOs have advocacy structures in place, "but they don't know what to advocate." Jane agreed that governments "sometimes talk about coalition-building, but for what — as if it's an end in itself."

Isaac stressed the importance of stakeholder involvement. He said he could imagine reasons for an NGO like this one to exclude partners from other countries, "because the organization wants to have control of the program. But, again, I've seen instances where projects were conceiv-

ed in Canada and flop in a developing country, because they don't really know the needs of the people....You cannot design something for anybody without knowing the needs of that recipient," so stakeholder participation "must be included in the plan right from the bottom".

Some participants said the NGO would not require such a broad consultative mechanism to take part in domestic lobbying for umbrella aid programs. Linda Ross said the Canadian Council for International Co-operation has been lobbying against cutbacks in CIDA's Official Development Assistance (ODA) program, and suggested that the NGO could take part. "It's been a massive sort of rallying initiative," she said.

Carlos gave three reasons to start the process of developing a mandate by meeting with the authorities who dictate policy. First, if the NGO is going to work in the area of health in development, it will have to demonstrate that the concept exists. Second, any activity on health in development is related to external government policies. Third, a conversation with policy-makers can be the basis for coming up with a work plan. It may not be a coalition model, Carlos said, but it might constitute a survival plan.

Lynn said the group's suggestions had been extremely helpful to her. "I've worked passionately for public health in this province, and I knew exactly what I was advocating for," but the notion of improving the world through health in development "just doesn't have the same tug appeal". The group's feedback helped clarify that the NGO was moving into advocacy under a form of false pretence, she said, because the decision to form the three subcommittees came too soon after a major transformation in the society itself. The result is that "we don't have that kind of background as an organization that has a social justice context."

Even working alongside CCIC would fall short of clarifying the NGO's value system or building a deeper understanding of health in development, Lynn said. "The problem with all of this is that this is agenda items," and "not a real philosophical visioning decision." One problem for the NGO to grapple with is how anyone can run a national association without branch affiliates that can bring "the connectedness that is so important". Rather than setting a one-hour maximum for the discussion, Lynn said the NGO's board should agree to undertake a more fundamental process of reflecting on its own core purpose. "The business of an organization is to constantly look at itself and renew," she concluded.

The Cuetzalan Experience — Carlos Coloma

Debbie summarized the "very complex and interesting story of an evolutionary situation that occurred in Mexico", where an abandoned hospital with "ghost doctors" and very little money was revitalized. A dentist and an agronomist were selected to work with the people to try and create some kind of health system; the main qualification for the job was an interest in helping the people. The two workers called upon the traditional healers to work at the facility and used the church in the hospital for ritual healing, and "the attendance at the hospital went up 1000%. People just started coming." Funding began to materialize, and the hospital became the venue for a complementary working relationship between the healers and regular doctors.

The hospital came to be seen as a model, and the Mexican government asked the two catalysts to take responsibility for setting up five or six more facilities. They refused, Debbie said, "but there began to be all the tensions between doctors and healers, between Indigenous and non-Indigenous groups." Eventually, the healers expressed interest in having their practice legalized, but

indicated they would be unwilling to pursue the matter without a complete review of the hospital system and medical curriculum. The case raised questions about whether it's possible to combine traditional and western medicine or create lasting agreements between community institutions, and ultimately, whether this type of arrangement can be institutionalized without it being diminished or destroyed.

The group identified a series of problems with the case, Debbie said; their main question was where to start in order to make a difference. Part of the problem is that the approach is determined by the type of campaign envisioned: a runner takes a different approach for a 100-yard dash than she would for a 220-, 440- or 880-yard run. The group came up with four options:

- Change the medical curriculum, despite the nervousness of students, established physicians and patients;
- Become more aware of the alternatives, despite the risk of creating confusion and controversy;
- Create a hybrid of western and traditional medicine, after looking at all the linkages among the various options;
- Establish a forum to foster improved communication among healers, students, users of health care services, doctors, and people from other cultures, so that people would have an opportunity to listen to each other and "the individual goes away with more ability to make choices".

The group chose the fourth option because it seemed like the most positive way of solving the question of where to start. In this way, it was felt that improved communication would set the stage for further consideration of whether traditional and western medicine can be brought together in a complementary way.

Lynn asked how long the forum would have to go on, suggesting that "it's not one event. It's a series of activities." Debbie said the comment reminded her of Shirley Lyall's frustration at having to tell her story over and over. The group thought of suggesting a more varied discussion to help people broaden their thinking about health options, but "if you started it, would you come to an end or would you just have to keep doing it?" Caroline said it might also be possible to use the energy that already exists in informal education networks, to deal with the issues and create opportunities for dialogue. Purnima suggested using video, and Joan noted that some viable models for community media are in place in developing countries.

Kay asked whether it would be possible to move away from references to 'western medicine' and talk about health care and doctors instead. Carlos expressed concern that "it would be a very fragmented approach to what health means, because the western concept of health is very fragmented. It just isolates one aspect, whereas in Indigenous health, there is consideration of a variety of other factors that bear upon health." Compared to a system that focusses on individual condition, biomedicine and public health, he said Indigenous health systems start out from the diverse and move towards individuals. This difference makes it very difficult to apply western definitions to Indigenous health, or to compare the work of a healer and a doctor.

Feng said holistic models of health care already exist in countries like China, where traditional and western medicine often co-exist in a single hospital — practitioners even refer clients back and forth. "They're pretty much in harmony," he said, except for practitioners at the extreme of each tradition who can see no value in the other approach. People in the middle take heat from

both sides, but Feng stressed that "nature will take its course...We need to work together and complement each other, rather than fighting each other."

Purnima recalled discovering a pocket directory that chronicled a doctor's home visits over a period in 1910. The book demonstrated physicians' awareness of a wide range of physical signs, and also reflected routine use of traditional diagnostic techniques. She also noted that nurses' training has evolved from an era when students were actually taught to look at the natural course of a disease. Carlos noted that China has a medical tradition that has been continuous for 2500 years, and noted that there is similar depth in Aboriginal health practices. The challenge, he said, is to determine the degree to which the different traditions are compatible and create a new system that incorporates all three.

Understanding Culture: A Basis for Coalition-Building — Purnima Sen

The participants reviewing Purnima's study focussed on the deteriorating relationship between the second co-operant and the host country, and considered the structures within current aid structures that contribute to problems in-country. One group member felt the co-operant should have known better than to be arrogant or distant with people from the host country. But at least one other member felt the problem was deeper than the process of identifying and training project staff. She described the stress and isolation that is often experienced by Canadians overseas, and speculated that the project manager in Purnima's case may have seen control of the vehicle as the only thing he could hold on to.

Building Coalitions to Improve Maternal Health in South-East Nigeria — M. Kay Matthews

Kay's group placed the delivery of maternal care in South-East Nigeria within the broader context of the workshop theme of primary health care. "What I got out of it was the sharing of the perceptions from Carlos and Ravi," Kay said. "They have a particular perspective, which wasn't really new to me, but it reinforced to some extent what some of my dilemmas are in international health. I guess the lesson of that is, when we think we're providing a solution, are we in fact a part of the problem?"

Before lunch, Kay had shown a video on current maternal health issues in Nigeria. Participants saw the production as "very moving and very upsetting, but also illuminating, because most people didn't really understand the extent of the problem," Kay said. "However, particularly Ravi and Carlos perceived it as being very much in the medical model — which it is — but also that that's the perception of the people who put it together."

The discussion turned to whether the medical model is appropriate within the Nigerian culture. "I guess the feeling was that, possibly from a lack of cultural understanding, it was very possible that we could be contributing to the problem by trying to replace the strengths within the community with a western model of medicine." When they looked at the appropriateness of intervention from outside, participants in Kay's group "felt there were really inherent flaws in the philosophy and the approach of the project — which led me to express the dilemma, which is how can you make sure that what you do is appropriate? Is it appropriate to even be there, which is some people's philosophy? And at the same time, in the developing world, can we stand by and watch maternal mortality and morbidity rates which would be totally unacceptable in our own society?"

"The whole issue is fraught with controversy," Kay said. "I came away with the same sense of dilemma at the end of it as at the beginning, and that's probably the way I ought to feel, to understand that the answers certainly don't rest in us. They rest within the community in Nigeria and they, in fact, know what they need. They perhaps just need some of the financial resources to realize" their objectives. Kay said Nigerian women and health professionals have identified the need to educate traditional birth attendants to recognize signs of complication, and to fund appropriate health facilities so that physicians and midwives can respond appropriately in an emergency.

Strategy Synthesis Leads to Further Analysis

The third day of *Advocating for Health — Building Coalitions* began with a presentation by Lynn, intended to synthesize the strategy points that had emerged from the case study sessions Friday afternoon. She said the discussion had revolved around three issue areas:

- Strategic ideas about how to support the role of the advocacy worker and coalition-builder as a catalyst or focal point for change;
- Strategies to establish an advocacy group or coalition, then manage or facilitate that group's effort to arrive at some kind of vision;
- Effective strategies for achieving actual change through advocacy and coalition work.

She noted that a concept of partnership was at the root of all three issues, and drew the following ideas out of the previous evening's discussion:

- Even a big problem can be overwhelmed by a bigger one;
- Being isolated in one's work;
- Big problems can be overwhelming;
- Coordinators doing advocacy work need support, assistance and resources;
- Coalitions should consider alternative pathways for delivering their message, such as video;
- In the process of agenda-setting, it is crucial to include a process of broadening ownership of the problem, and recognize the potential for agenda-taking or -sharing;
- Strategies for communicating with authority are very important;
- Coalitions should ask themselves whether they are negotiating real control or a custodial relationship;
- Cross-cultural issues may actually be cultural conflicts once groups go beyond the "cordial, polite bounds";
- A vision needs to be articulated and shared within the group, and with others;
- Catalysts must be careful to take direction from within the community;
- Political action is a real but risky strategy;
- Mobilization of people may be a powerful way for a coalition to make its point;
- Organizers should not assume people understand them, and must recognize that multicultural sensitivity can lead to over-generalization;
- People from different cultures, or with different experiences, will have to tell their stories over and over;
- Politics can take you off-track;
- A solution that's too broad may be no solution at all;
- Coalitions must examine what level of control is really desired by the people, recognizing that gradualism may be the 'right' answer;
- Sometimes people want to be left alone, and have no desire to seek support or take part in a coalition;
- Organizers should get help before they get started;
- Coalition structures should be built on the understanding that form follows function, so a lot of time should set aside for the task of clarifying visions and expectations;
- Coalition workers should continually seek to renew and clarify their mandate through genuine communication and reflection;
- Groups should acquire the skills they need once their task has been defined;

- ► It's important to check in with the grassroots frequently for advice and guidance;
- ► Energy from the field should be channelled;
- ► Coordinators should create their own informal support groups in their home communities, particularly if they are involved in national or international activities and feel isolated from their organizations;
- ► Commitment from an organization means more than just saying you're committed;
- ► Advocacy and coalition-building should be seen to grow out of specific issues, rather than taking place for their own sake;
- ► Advocates must continually check in with their partner group, to ensure that their activities are actually enhancing people's lives and addressing their needs;
- ► Coalition work can be based on complementarity, co-existence, or conflict among partners, but the best relationships are built on collaboration, communication and exploration;
- ► There is a natural tension among healers from different health traditions;
- ► It can be difficult to know whether a coalition or a campaign is at the beginning or the end of its circular path, or to predict the pace at which people will be able to travel it;
- ► Confusion and controversy arise when groups try to change the way things are, so organizers should be prepared for the risk involved;
- ► We jump into decisions too soon;
- ► The media can be used to empower the community;
- ► Mutual understanding is arrived at through exploration;
- ► There is a challenge to bring about a new thinking and way of looking at health.

Based on her original list of discussion points, Lynn said six of the ideas had pertained to help for the coalition-builder, 35 had to do with "basically getting one's house in order" in establishing a group, 14 covered or overlapped into the task of supporting effective groups, and six dealt with the development of partnerships.

Debbie said the synthesis had helped her think about the lone advocate or coalition-builder, and whether there are some things an organizer is unable to do. Lynn said the question turned on the presence of a mandate from a broader group, but Sheila said it's important to say no if the mandate isn't reflected in tangible support. "If you've done everything you can to get that support, then there's room for abandoning or postponing the cause." Lynn agreed that there's an obligation on any coalition partner to put meaningful support, be it formal or informal, behind any commitment to coalition-building.

Barbara said groups often tend to take their coordinators for granted, to which Sheila responded by stressing the need to ask for support. Jane said the coordinator's job is to help the broader group understand its role, not to come up with the plan and do the advocacy. "There's that tendency that if you're going to do the advocacy work, that's your job," she said, and "as an organization we're kind of off the hook."

David said the discussion was an interesting reflection of the process within progressive organizations. He stressed the need to strike a balance between letting the people who know the issues do the work, as opposed to delegating the responsibility so that it can be shared. Ultimately, there must be some process for including people equally in the decisions and activities of the group.

Lynn said coalitions and advocacy groups work on points of strong principle because their focus is on issues. As a result, delegation of responsibility often leads to a backlash against a particular course of action, and staff end up feeling unappreciated or victimized. "What you often see is that you destroy people within by a lack of appreciation, or by changing the rules," she said. "That's a very important, deliberate negotiation that has to happen, and it sneaks up on you." Mitchell said the group is just as vulnerable if an individual coordinator or spokesperson can be isolated and undermined, whether by external forces or by in-house disagreements. In this sense, he said the entire group has a strong interest in the negotiation process that Lynn had described.

Ravi said individuals can become isolated, but can also isolate themselves because of their personal style. He said the limited number of action items in Lynn's list made sense to him, because "the whole group-building process disappears" when there is one strong individual in an organization who is very clear about a course of action. "Over a long period of time, we find that a lot of coalitions are in trouble because their leadership is burned out, and they're too busy doing things to reflect."

Lynn said the picture is complicated when a coordinator is hired to execute a plan that is already established. Barbara said a major problem in Nova Scotia is the high degree of politeness between committee members and staff. "I feel like I don't get as much feedback as I would like from my group," she said, "and that's not very satisfying... It can so easily happen that then there comes to be a backlash," by which time the group has developed a good deal of hostility. Lynn suggested identifying one or two close friends within the group and asking them to respond to different situations with constructive criticism only, as a means of gaining perspective on ongoing work. Debbie recommended a project plan with clear checkpoints or milestones for evaluation, and David said coordinators can get valuable feedback by setting up a ranking activity, in which group members are forced to identify aspects of the work with which they are most and least satisfied. Even if people say they're entirely satisfied, a quick scan of the lowest scores can provide helpful information.

Ravi stressed the importance of allowing time in all our group work to find out how people are feeling. "I think it's important to churn things up a little bit," he said. "People must feel free that that session is a session for sharing."

Linda emphasized the importance of finding common ground with coalition partners, and of keeping in touch with the grassroots to ensure that the coalition activity reflects people's interests. "You have to be sure that your membership, in fact, wants to be a part of that coalition," she said. "You need to know that the organization is supportive," even when the leadership isn't at the table. Involving more than one member of a group in the coalition process is a good way to build broader interest and support, and also contributes to the credibility of the coalition itself. Juanita said she had seen coalition processes where some representatives never reported back to their groups, so that the groups eventually sabotaged the broader effort. Lynn said the problem may have stemmed from a lack of communication and consultation skills, to which Juanita responded by stressing the importance of "taking the time to really know where people are at, and what they're understanding. Some of the people absolutely, in their work situation and in the way they operate in the world, do not follow process at all. So there's something really wrong, and you may not realize that until far into the game."

Andrea noted that "even those of us who have some sense of democratic process think of it as a linear thing," when in fact "it's a dynamic process, and it's about relationships. The communication has to be ongoing....We live in a culture where everything is linear, and that's how rational processes work. But we have to think in a more non-linear way about how we work and how we relate from one group of people to another." Jane said some organizations have no interest in process, pointing out that some people do needs assessments, then just do what they want anyway. "The idea of following a process is foreign to a lot of us that are used to working a lot more spontaneously," she said. "We've been trained in hierarchical systems, and we're really not comfortable with the concept of partnerships and working together."

Andrea said she's seen an increase in interest in democratic process skills since her years as a student activist, but Miriam warned that some members of an organization might become impatient with process training. "Unless they're completely dedicated to what they're doing, they're not going to be patient and think about the long-term benefits," she said. Debbie suggested that that might make process training a good test of people's commitment. Karen said the advocacy group in her community was anxious to take on specific tasks, "but the group is taking a long time just to understand the whole notion of primary health care. We have to keep going back to that. If we don't put down the foundation, anything that happens afterwards will not be effective."

The session ended with a sharing circle, in which participants brought forward thoughts and concerns about the workshop process so far. (Details were off-record, but several participants enthusiastically noted Feng's commitment to host a follow-up workshop in China within 10 years! Sheila said Lynn's synthesis had covered many of the skills that her 17-year-old son is using as a high school peer counsellor, and predicted that her son would *definitely* be keen to attend an event in China!)

Concurrent Sessions Focus on Strategies for Change

Small-group sessions on Saturday morning and afternoon focussed on specific aspects of coalition work. Joan and Juanita set the stage for the discussion by putting forward some specific definitions of coalitions, then listing two objectives and four questions put forward by the workshop organizing committee.

Juanita noted that the Saskatchewan Primary Health Care Coalition had defined coalition work as "a strategy enacted by community-based organizations to achieve economic and social change," and described coalitions as "groups agreeing to work collaboratively to achieve specific objectives or common goals". She said a coalition could also be defined as "a political alliance that acknowledges equality and equal development within a partnership". Juanita invited participants to use the small-group sessions to talk about ways of getting past the polite agreement on issues, dealing with hidden agendas, setting out ideas and milestones, and getting people to check in with each other as the work proceeds. "Basically to all of this, we feel that real, honest, open community is such a factor," she said. "That goes a long way with any coalition-building, and I think there will be lots of opportunity to look at that in your groups."

Joan suggested that the two objectives for the concurrent sessions should be to:

- Identify strategies for coalition-building to advocate for health at the personal, community, and organizational levels; and
- Draw out lessons from our personal experiences with coalition-building and advocacy.

She asked participants to base their discussion on four questions:

- What is the role of the advocate/coalition-builder?
- What are the skills and resources needed to manage people who want to build a coalition to advocate for change?
- How does a coalition function in order to successfully influence a group or a policy?
- What are the issues that need to be considered when entering partnerships for coalition-building?

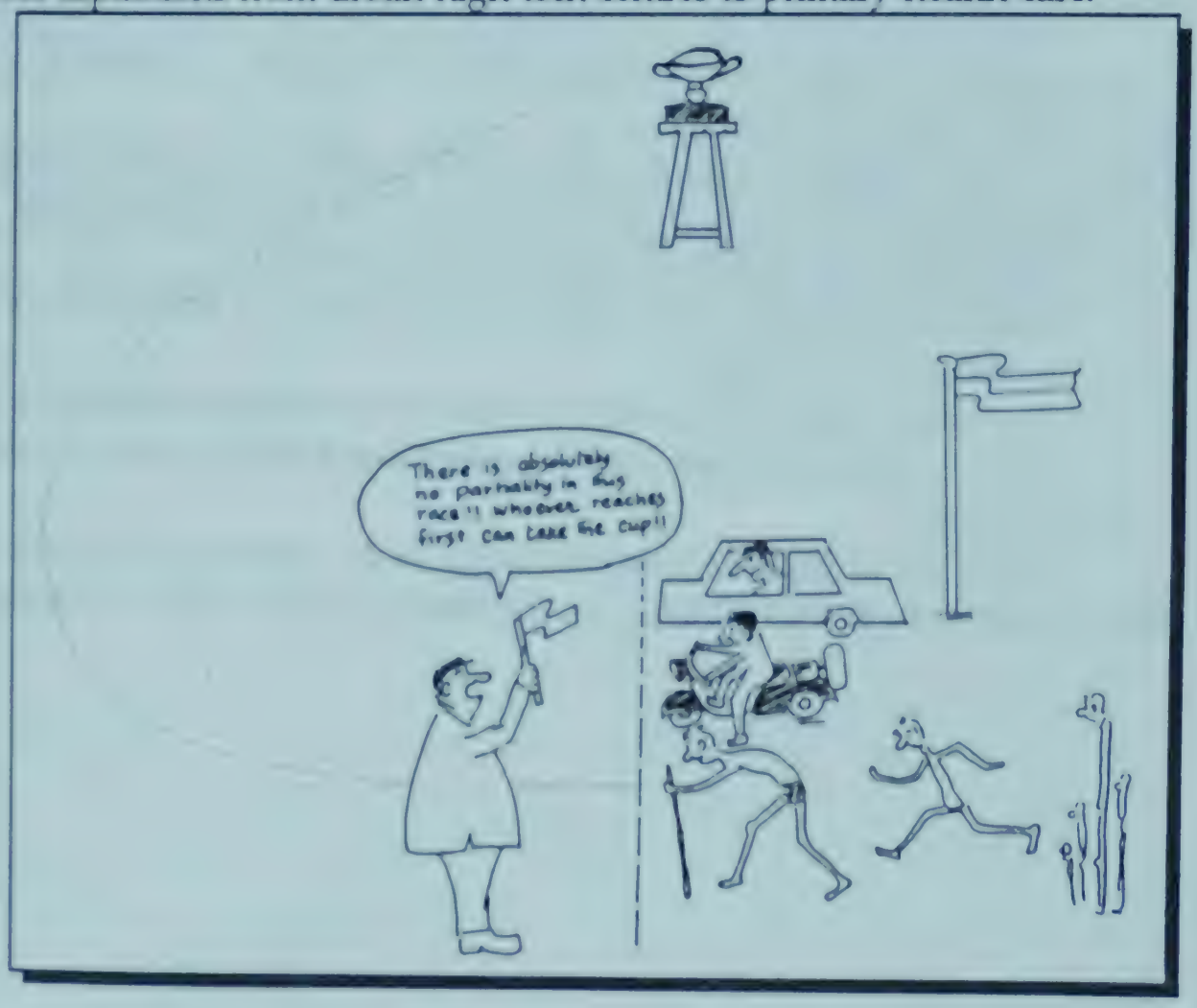
Discussion of the four questions began in the morning, continued in the afternoon, and was reported back to the full group on the final morning of the workshop.

Reflections from Ravi Narayan

The third day of the workshop ended with a presentation by Ravi Narayan, in which he used cartoons, photos and overheads to trace his own personal journey in community health and address some specific questions around the process of building coalitions.

Ravi recalled that his first serious doubts about the western medical model came out of his experience working in Bangladesh refugee camps in 1971. "The medical model didn't prepare us for work in the community, and so I decided that one response to that reality would be to get back to medical school, and help to change the teaching program...orienting it towards the challenges in community health." Ravi and his wife joined the department of community medicine, and spent about 10 years trying to take students out of the institution for community-based experiences.

A serious problem eventually became obvious, Ravi said: the impact of a teaching program depends in large part on the students' long-term objectives, but most of the students in medicine were setting their sights on careers in high-tech hospitals in Indian cities, the United Kingdom, and the east coast of the United States. Ravi and his wife realized they could have an impact by making students look forward to a trip to the bush, but didn't know how to change values on a larger scale, that could move career aspirations from urban high tech centres to primary health care.



The Narayans eventually decided to leave the school. "We felt we were wasting our time helping people pass an examination, but they weren't going to get to the community." They gradually began to unlearn some of their medical school experience, by sitting with community-based health workers, non-medical workers and community people. But because of their academic backgrounds, they immediately became interested in establishing a nucleus multidisciplinary team and network of resource persons who would serve the community while generating an understanding of the common features required to make the model work, based on a linkage between "macro" issues and grassroot realities.

Ravi had been educated in the medical model as a post-graduate, "so I have all the credentials that now give me the permission to say I don't believe in it anymore." But "the first thing I began to find was that what we were offering the people, with the best of intentions, was inappro-

priate," for reasons that included the cost of service, the top-down nature of the approach, corruption, communication gaps, reliance on drugs, and the fact that the medical model only offered temporary relief. "To me, these are not intellectual conclusions," Ravi said. "I can relate each of these to specific things that happened."

Experience also helped clarify the economic, social and cultural roots of ill health. Ravi said it was "most disconcerting" to come up against the assumption that life was a race — particularly because the cultures and individuals running the race had unequal access to health care. To illustrate this point, he used a cartoon *(please see previous page)* showing one person in a car, one on a motorcycle, and two others who are lame and ill. He stated that health action can reach everyone equally only when it reaches those who do not have access through positive discrimination towards them.

As a result of this rethinking, Ravi said, "we discovered that the issues we had to deal with were not just medical problems like diarrhea and tuberculosis and leprosy, but societal factors such as homelessness and exploitation and poverty." Community organizers, non-formal educators and developers all emerged as important partners, as Ravi and his colleagues realized that the key to good health was to re-educate physicians toward a people's agenda. The approach ultimately meant moving away from doctors, nurses and the medical model, recognizing that "whatever we do in health, must be within the dynamics of a community of social diagnosis. Much of what we do has to be at the level of the community," despite the difficulties that technically-oriented professionals face in moving toward a community context.

Medical and Social Health Models of Community Health Development

Medical Model	Social Health Model
Individual ——————>	Community
Patient ——————>	Persons/people
Disease ——————>	Positive living
Providing ——————>	Enabling
Drugs/technology ——>	Knowledge/social processes
Predominantly physical –>	Physical/mental/ social/political/ecological/ spiritual
Professional control —> of skills & knowledge	Demystification and greater accessibility to lay skills and knowledge
Biocellular research —>	Societal/behavioural research

After a few years of grassroot work, Ravi took a year off at the London School of Tropical Medicine and had the opportunity to conceptualize the shift from the medical model to a social health model (please see accompanying chart). While the health professions must shift more toward the social health model, Ravi stressed that the arrows pointing right were intended to convey the need for both approaches in dialogue.

The Community Health Cell and its associated Network has been involved in a great deal of formal and informal training, most of it participatory, Ravi said. "We haven't got any formal courses that lead up to diplomas or certificates," he explained. "We identify

groups of people who feel they need to explore something, and we build up a participatory process of exploration. It's always looking at it in terms of health, and in terms of community." The group does a lot of networking, and acts as a technical resource group and information advisory service for community-based practitioners and projects in the non-governmental voluntary sector.

From an epidemiological perspective, the concept of health for all involves three factors: environment, host and agent. Ravi said the role of the CHC is to build linkages, acting as agents of change with development workers, health workers, and not directly with communities. The Network has a few full- and part-time staff, and a large number of associates who help meet the needs of specific community-based projects and initiatives. When people visit, write or call the CHC, the focus is on talking with the potential partner to see what specific supports they require.

Ravi concluded the first part of his talk with a quote from Gandhi that described the facilitative role that the CHC Network attempts to play:

"I will give you a talisman
whenever you are in doubt...
Recall the face of the poorest and most
helpless man or woman whom you
may have seen and
ask yourself if the step you
contemplate is going to be of any use to him or her...
will it restore him or her to control
over his or her destiny?"

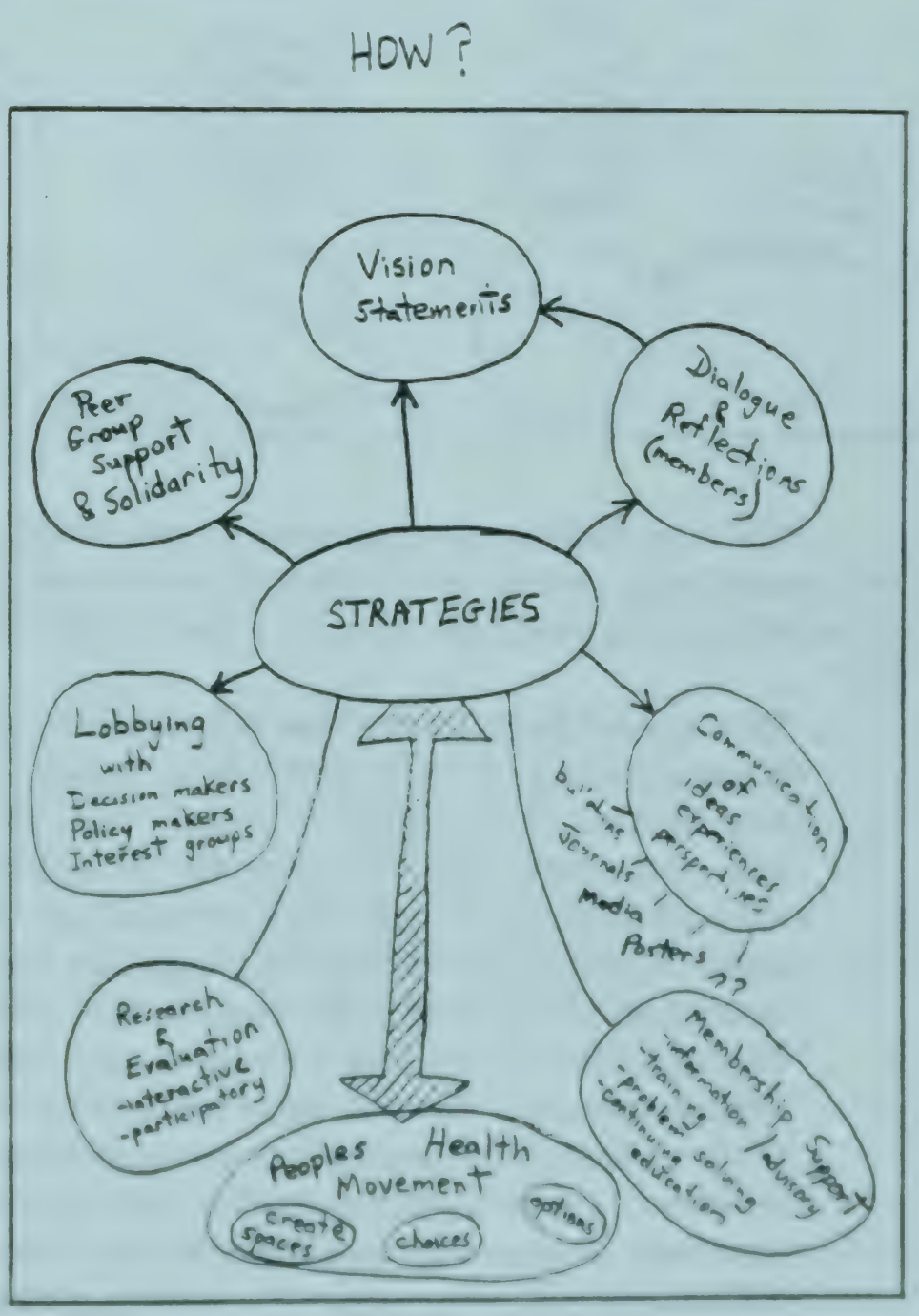
In a brief question period, Isaac asked Ravi how his team was funded after they left the medical school. Ravi said they weren't sure at first how they would make ends meet, but they knew they had to leave for their own mental health. One option was to launch a field-based alternative health service or a training program, but there were administrative problems with that option. The group decided to provide a professional/technical information and advisory service to community health action initiators in South India. This was not, however, on a fee-for-service consultancy, because the group was concerned that clients in the greatest need would be unable to pay. Over time, they learned that clarity was more important than immediate funding: even in a country like India, Ravi said, "there are a large number of people who want to support our work". National and international agencies have funded specific parts of the Network's program, and a Friends of CHC scheme has been formed to raise funds from other sources.

Purnima said she was very impressed with Ravi's efforts. "I know what a tremendous task you have undertaken, and the success you have experienced is really something." Ravi stressed that the success belonged to a group of 12 staff and 25 associates, not just to himself. "What has sustained us is not so much money, but the discovery that there are so many others in India who are doing the work," he said. "All of us move through periods of intense involvement, being burned out and being rejuvenated, and we need that peer group support."

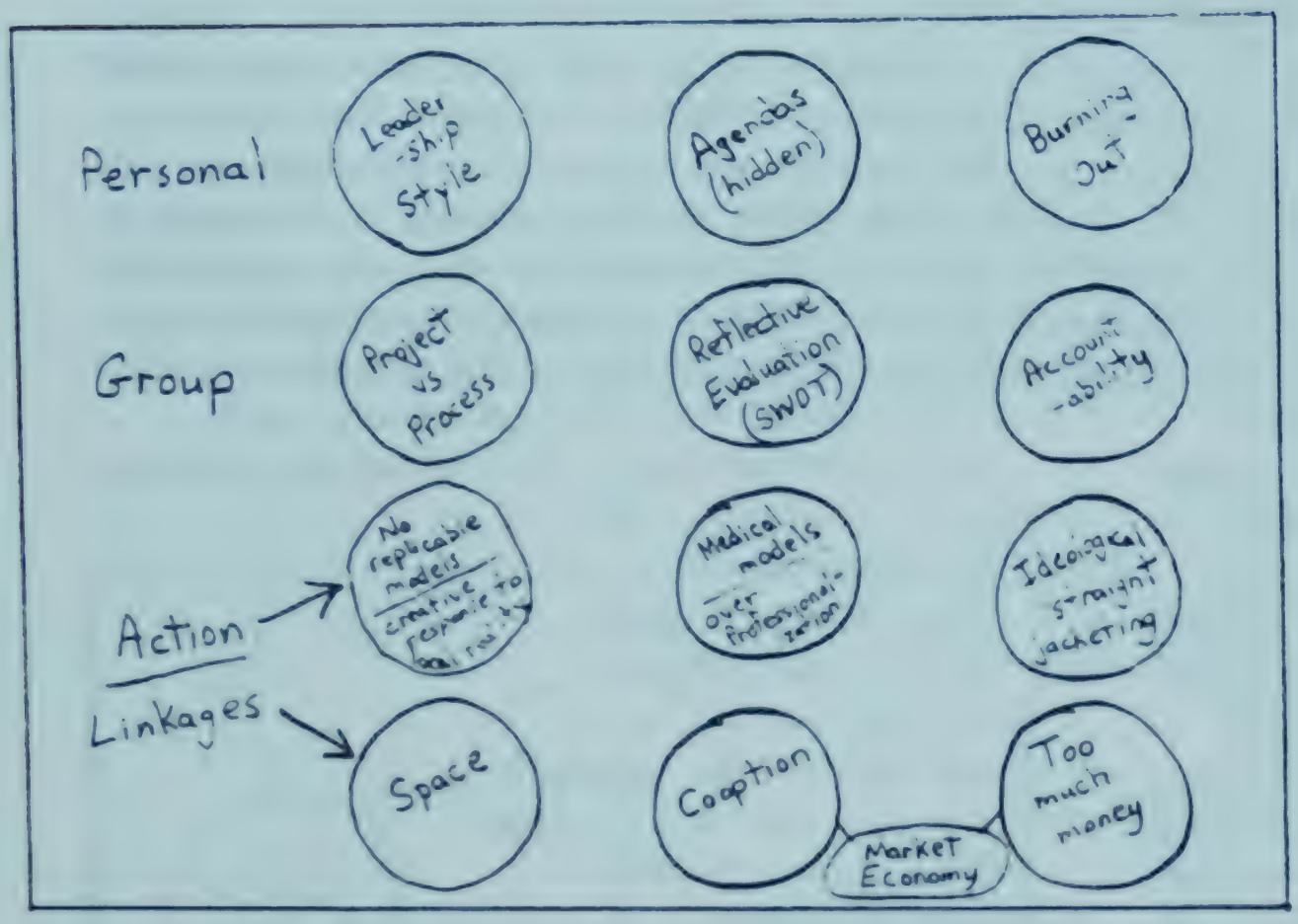
Lynn said she was fascinated with the idea of being an agent, noting that North Americans would normally call such a person a facilitator. Ravi said they had shied away from the word 'consultant', because of the private sector connotation. "You soon start working with people who can afford your consultancy, and the challenge is really to work with people who can't afford it."

In response to a question from Feng about the origins of the Network, Ravi underscored the importance of creating a healthy space in which to promote good health. Before the Community Health Cells Network was established in 1982, there were a number of people in India trying to build health democratically, "but were really not experiencing building democratic, healthy teams," he said. "You can't expect the traditional birth attendant to really sit with the mothers if the nurse who trained her keeps talking down to her, and the doctor who trained the nurse is hierarchical." As the most senior member of CHC, Ravi said it was difficult for him to put aside the authority of his position. "I'm still the most verbose and maybe the most top-down member of the team," he claimed. "Trying to be truly participatory is not an easy thing if you've been too long in the system. But over the years, by giving time to the team-building process, we have evolved a more participatory, healthy process."

Ravi used a series of before-and-after slides to demonstrate the difference between the medical model and a more holistic approach to community health development. After a round of audience discussion, he provided a brief history of India's health system, noting that it was clear by 1972 that a 20-year effort to extend the medical model across the country had been an obvious failure. A sharp focus on the needs of the majority grew out of a recognition that there are really two Indias: the 200 million people who have access to resources and constitute the third-largest concentration of scientific expertise in the world, and the 600 million who will be further disenfranchised by a globalized economy. Ravi stressed that the poorest people must be the centre of the health planning process. The Community Health Cell is part of a larger national network that discusses issues of empowerment and societal issues that have a bearing on health at its meetings twice a year, and raises specific problems and concerns through its bulletins and newsletters.



Turning to questions of strategy, Ravi said any vision statement must grow out of dialogue and reflection involving the members of a group. He took note of participants' concern about



clarifying their vision, noting that "we have the other problem — sometimes it's all vision and not yet action." Either way, he said it's important to maintain communication with members and with like-minded networks through bulletins, journals, posters, and the media. Research, evaluation and lobbying are also important, but the single most significant task in maintaining a coalition is to support people and build solidarity among them.

The other challenge is to maintain contact with the grassroots. "Somewhere along the line, we're beginning to wonder if we've lost the people someplace," Ravi said. "You have to make sure you're still touching base...you can get a vested interest within a coalition, in your own salaries and jobs."

He suggested the following lessons based on the experience of the Community Health Cell:

- If you're trying to clean up from a flood, it makes more sense to turn off the tap than to mop the floor. It's important to do both, "but I feel we're not doing tap-turning-off at all, with all the cherry-flavoured mops that the multinationals are producing."
- We can't be part of the solution if we're still part of the problem. Recognizing this dimension of reality is a prerequisite for change. It's important to share our concerns forthrightly, rather than being overly polite when we hold meetings.
- Paradigm shifts are required if we are to move beyond the medical model.
- We must recognize the need for an integrated process of coalition-building, in which health outside is linked with healthy groups and individuals, and adequate time is provided for reflection. "We get caught up in that need out there," Ravi said. "There's so much to be done and, we sometimes question whether we can justify stopping and getting down to our feelings." However urgent the issues might be, "we still need to know who we are and why we're doing it."

He concluded by identifying a number of issues facing coalitions, including personal issues of leadership style, burnout, and hidden agendas; group issues centring on reflective evaluation and the need to separate project from process; and action issues, growing out of a discomfort with

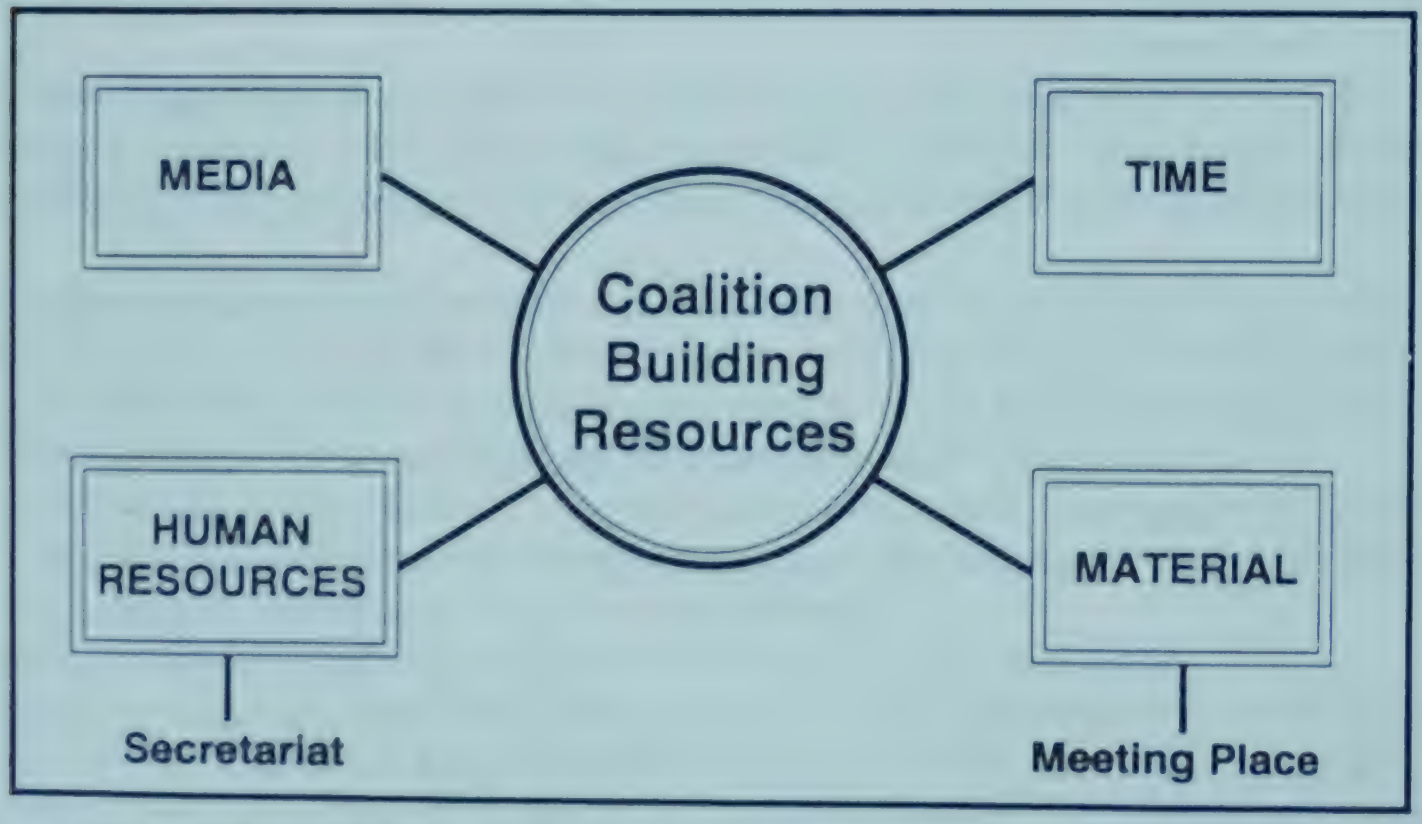
fixed models for coalition-building. "We need to see that every situation, just like every human being, is so special," Ravi said. "If you need to have a model at all, it's not to try and take something from some other place. The model is that there's no replicable model," except for "a creative response to local reality". He concluded by citing the medical model and over-professionalization as an ideological straitjacket that can grow into international public health strategy: "I can't help feeling that these are all really fundamentalist sorts of positions," he said. "Really, we should get beyond those sorts of ideas."

Closing Synthesis: Group Reviews Learnings from Strategy Sessions

In the last formal session of the conference, participants discussed the insights on coalition-building strategy that had emerged from the concurrent sessions Saturday afternoon. Juanita and Joan presented the following summary of participants' answers to the four questions:

- **What is the role of the advocate/coalition-builder?**
  The coalition-building role (like leadership) is collective and shared among the group.
  It includes issues identification with community involvement, information-gathering, listening, clarifying, identification of an achievable goal, and flexible commitment.
  The role most also include respect for diversity, recognition of each person's value, work and contribution, and provide equal opportunity for all members or groups within the coalition.

- **What are the skills and resources needed to manage people who want to build a coalition to advocate for change?**
  Skills for coalition-building include research skills, process skills, political savvy, flexibility, responsiveness evaluative ability (quantitative and qualitative), ability to nurture individuals while retaining collective spirit, and management and leadership ability. Resources are reflected in the following chart:



- **How does a coalition function in order to successfully influence a group or a policy? What are the issues that need to be considered when entering partnerships for coalition-building?**
  Issues and challenges include:
  - Understanding the principles of partnership;
  - Fostering mutual respect, understanding and collegiality;

- ► Knowing when to let go;
- ► Learning when and how to involve politicians and bureaucrats;
- ► Learning to share information with coalition members before seeking resources.

In introducing the summary, Juanita said the organizing committee kept coming back to the idea that there are no prescriptions for coalition strategy. Joan said the working group results were "totally congruent" with Ravi's visual representation of strategy issues, which was far more comprehensive than a collection of words. "I think there is probably some frustration, certainly on the part of some of us in the planning group," because strategy development was one of the objectives that participants had identified for the workshop. But "it's important that we remember that there are many strategies, and all we've looked at in any detail are coalition-building and advocacy as two possible strategies." The results mean that the detailed work of articulating strategies for specific situations "will have to be done by all of us when we get back in our own situations, and decide which groups we're going to be talking with."

Purnima agreed that if the group was looking for concrete answers "we're in for disappointments, because when you're dealing with human beings there's never a neat 1-2-3-4 answer...You also have to remember that there's never any real solution to any human problems: We solve one problem and create others. The question is, which is better?"

Debbie noted that all the answers presented by Juanita and Joan were part of a larger picture. "None of these things stand alone, and the political savvy is that you've defined the issue and the way you would like things to be if the issue were addressed." She stressed the need for a process of opportunity sighting, "where you can see a place where we would like to take action or make a move now."

Ravi said the ideas brought forward by workshop participants had been more focussed than the discussion seemed to suggest. "Many of us come to workshops because we want concrete things, which I think, itself, is a block. I've found lots of concrete things that people have said, even just the response in so many of your experiences and the difficulties we've had," he said. "We are in a very prescriptive culture, and that's one reason we're coming here. We want someone to tell us to 'go and do this three times a day,'" even though we know that that's the medical model. One of the lessons from the workshop is "that we need to go out with the people, to sit with them and work out solutions." "We need to learn from each other's experiences, but no one experience will be a solution for another," Ravi continued. "We need to go back feeling affirmed that it's us with the people, and the group will arrive at the solution....That's a very concrete thing to take back."

A Bamboo Strategy

Joan said she remembered when development funders had begun building concrete block housing in the Philippines, and noted that the approach was not appropriate for the communities involved. "Rather than concrete, I'd rather have it be bamboo, which survives a long time and is flexible," she said. "Maybe we could have a bamboo strategy." Kay said she'd learned "that in trying to find a solution, that we don't actually become either a part of the problem, or contribute to the problem." Feng cited a Chinese proverb, which holds that words mean nothing and action is the most important thing. He said he hoped to launch one or more health in development projects, and asked everyone to help him get started. Lynn summed up much of the discussion by

observing that the principles developed in the strategy sessions could form the basis for decision-making in a variety of contexts. "It's the constant course correction as you take it through real life," she said. "Your tool kit is the principles to come to the decision, and not the concrete strategy."

Carlos stressed that all the elements of Ravi's framework would become operational through the skills or conditions that lead to specific strategies. He said a central point in trying to define strategy — a concept which, he noted parenthetically, derives from the military — is for a group to decide whether it is talking about a process, program or project or actually preparing for it. If we see health in development as a process and we're working in another country or culture, we will understand that the direct path to a strategy is not necessarily the shortest. A long process of negotiation is needed to define our terms, but the process will be much more clear for the up-front effort.

This first phase requires well-organized work, "just like this workshop," so that "hyper-planification" becomes an important skill. But the process of defining objectives and time frames is a critical step in adding a "surname to the name" of the generic aspects of coalition-building. The worst thing a community developer can do is try to pre-define the process, Carlos stressed, because that would contradict the need to let other people think out their situation, make their own choices, and learn from one another. "We have a lot to contribute in strategies and ideas, but only as it relates to the process," he concluded. "The only position I would be willing to take would be to say we'll create this together, because each situation is different. Each community, each process is unique, even though there may be many things in common."

Linda said the discussion was giving her a new perspective on the impatience for change that she had expressed in earlier sessions. Canadians tend to expect results from projects within a year or two, or in time to write a project evaluation, she said, but people outside North America seem to work on a different time frame. Change is a slow process, she said, so maybe it's okay if we don't see results in one, two or 10 years. "I knew that inside," she said, "but maybe that's one of the things that we tend to forget." Ravi responded by citing Debbie's metaphor of a racetrack as a way of remembering that any beginning could also be an ending. "Development and change and transformation go on all the time, and in order to do that we have to set an end point," he said. He also suggested a new dimension for the field of international public health, based on a constant dialogue between Oriental and Occidental traditions. People from India appreciate the fast pace that many North Americans maintain, because "we feel that maybe we're going a little bit too slow." Ravi said a belief in reincarnation may make it easier to believe that "if we don't finish it this year, it doesn't matter." But he stressed that a mixing of the two traditions would be beneficial to all, noting that a new balance often appears in Third World professionals who study in the western tradition, or in western development workers who spend two or three years overseas.

Lynn noted that "we're all on multiple, swirling paths", with careers, professional activities and personal lives all proceeding along the same indirect routes. She said a busy schedule with many commitments might be one of the keys to feeling that progress is being made, even if the going gets slow. At the same time, she agreed with Caroline that it's important to take time to think and reflect on the paths we've chosen.

Closure Session: Commitments, Goodbyes and Evaluations

The closure session, the last two hours of the workshop, was an opportunity for people to say good bye, to evaluate the workshop and to articulate their commitments that resulted from the workshop. The content of the discussions was off record, but the process was important.

The ritual of a *Sharing Circle*, which had been used at other times throughout the workshop, began the closure exercise. By passing an object around the group, each participant was given two opportunities to speak their feelings about the workshop.

Participants then formed groups of about six to reflect on their own learning during the three days. This activity was carried out using a *Body Diagram* in which a large diagram of a person was drawn and then people discuss and write on the diagram: new insights around the eyes, new feelings around the heart, new skills around the hands, etcetera. It was a valuable 'debriefing exercise' and one group chose to draw a pictorial representation of the entire workshop rather than just individual learnings.

Participants were then asked to write *one letter and one memo*. The letter was to be to themselves — to be mailed to their home address five months in the future. This letter was to talk about their commitments — what they were motivated to do — as a result of the workshop. The memo was also for people to write to themselves to remind them — when they'll receive it five months down the road — to contact someone else from the workshop that they felt that they very much wanted to keep in touch with.

The final group activity, *'Back-firmations'*, was a fun, energetic one in which all participants had a large piece of flip chart paper taped to their backs. Participants than moved around the room and wrote affirmations or short personal messages on the backs of fellow participants. This activity gave each participant a 'souvenir' to take home that were comments from fellow participants.

Finally, participants were asked to fill out a short *Evaluation Questionnaire* to provide some more direct feedback to the workshop organizers. The results of this evaluation follow.

Participants' Evaluation

By the time the group reached this point in the workshop it was 12:10 on Sunday and everybody was ready to head for home — in fact, 11 of the 34 participants had already left. Of those remaining, only 13 took the time to fill out the evaluation questionnaires. From the comments aired in sharing circles throughout the workshop, informal comments and discussions, and the observations of the evaluation team these responses are considered representative.

1. What things worked well about the workshop?

Process (14 comments)
"way participation and communication were encouraged";
the participation process and all the facilitators;
constant consultations;
5-sharing circle and "other group rituals such as yellow and red times up cards";
2-energizers were fabulous;
sharing case studies

Diversity of participants/special guests (9 comments)
2-inclusivity;
multicultural/diversity/cross cultural;
international parallels and insights;
3-participation of international guests added much in terms of analysis and reflection and helped to link international and local context;
healers

Participants (6 comments)
process allowed group to create own great experience;
participants open minded and willing to look at any perspective;
group interaction and cohesion;
helped bring out our creativity

Organization (5 comments)
entire organization;
hard work;
scientific planning;
pre-planning before and during;"clear that organization did not end with the start of the conference but continued throughout the weekend with fine tuning as desired or necessary. That was a mark or great devotion/dedication"

Other comments
- venue was ideal
- everything
- emphasis on vision in international health

2. Is there anything that should have been done differently?

Time allocations (8 comments)
more free space (9 hours on Friday was too much);
crowded with possible agenda items;
mid afternoon breaks needed;
2-sessions sometimes rushed, evaluation session rushed;
more opportunity for exercise/fitness;
sitting all day and eating too much;
more equitable sharing of time for alternative healers — too much time for psychic

Content (4 comments)
more 'key note' presentations followed by discussion;
2-more emphasis on international dimension, but 2nd "realize the issues are universal";
Participatory Action Research could have been presented at the beginning as a contextual reference

Process (3 comments)
more heart sharing;
learning partners activity did not work;
maybe a fish bowl activity rather than skits for 1st activity as skits can intimidate, although they seemed to work well

Other comments
- cancel the snow and ice

3. What parts of the workshop gave you the greatest learning?

Discussing and Sharing (15 comments)
5-Case study discussions and then next day synthesis;
video and case study discussion over lunch;
2-group discussion of issues;
4-sharing individual and group experience, insights and synthesis;
4-sharing circle;
"came out of our heads and dropped down into hearts"

Ravi's session (7 comments)

Health in action sessions (2 comments)

Other comments
- times when I was least tired
- reflection/evaluation sessions
- different perspective on health

4. Any final comments for the organizers of this event?

Thanks (7 comments)
"what a treat it was to be here";
"for letting fates/'listening to' which allowed me to share experiences with everyone especially those who have been so reflective in their own work";
"I go away satisfied";
important work;
"it's one thing to talk about what a PAR workshop feels like, but so much more affirming and enlivening to be there"

Follow-up (7 comments)
2-Do it again!;
definitely like to be involved in a similar workshop and know of many people who would benefit;
maybe Halifax metro for a couple of hours to see how we've been making use of what we have given and taken

Organizers (4 comments)
obviously experienced in such ventures;
great work-you walked the talk;
excellent-you have kept to your philosophy of a participatory approach throughout;
job well done-money well spent;

Cautions (2 comments)
keep balance and critical thinking perspective, must avoid dangers of "group think";
more heart to heart less in the head

Other comments
- get better weather!
- we need more exercise especially with such great food

Graffiti Board

"The core of human development is spiritual and is rooted in the heart of culture."

Every workshop should have babies taking part!☺

DEFINE ADVOCACY!

Are you having a 'good' workshop?

The nature of graffiti is to scrawl in places where you're NOT allowed to scrawl!

- OK, FINE -- YOU/WE AREN'T ALLOWED (feel better?)

Great morning activities

What is your favourite book/author?

- ► Thomas Randall
- ► Alistair McLeod ++
- ► all Maritime authors
- ► L.M. Montgomery
- ► The Aquarian Conspiracy
- ► Marilyn Ferguson
- ► (getting out of date now but good) The English Patient by Ondaatje

I have a need to hear everyone's voice as an act of wrap-up when we've had dynamic conversation — as a form of dialogue so that if people disagree we know about it here rather than in the lobby.

A GREAT RESOURCE about working in partnerships for change is Getting to the 21st Century by David Korter

Outside is cold & grey —
Inside is warmth & colour —
thank you to a
great group!

GREAT ENERGIZERS!

TRUST ----> CHANGE

Afterword

Many 'reacquaintances', new friends and professional contacts were made during the three days at Tatamagouche. People found they shared similar challenges and visions of the future and there was much enthusiasm for keeping in touch and getting together again.

An address list of all the participants follows, and personal networking and communication will probably prove the most effective and sustainable method of networking. There seems to be a need for a regional structure, but it is something that will have to be created by participants themselves.

The letters and memos people wrote to themselves will be mailed out in September of 1993 and it is the responsibility of all participants to let others know of upcoming opportunities for getting together and continuing to learn and share experiences.

Materials brought by Dr. Ravi Narayan and others for the resource table are available for loan from the Lester Pearson Institute, 1321 Edward St., Halifax, N.S. B3H 3H5

The Canadian Society for International Health is an organization dedicated to making an active contribution to the evolving global understanding of health and development, and to networking with like-minded people throughout Canada. They are a good source to contact to learn what is going on in this field nationally. Their contact address is: #902-170 Laurier Ave, Ottawa, Ontario K1P 5V5.

Participants' List

Isaac Abraham
College of Pharmacy
Dalhousie University
Halifax, N.S. B3H 3J5

Joan Allen Peters
School of Nutrition & Food Sciences
Acadia University
Wolfville, N.S. B0P 1X0

Mitchell Beer
InfoLink Consultants Inc.
P.O. Box 4892, Station E
Ottawa, Ont. K1S 5J1

Kim Bernard
N.S. Persons with Aids Coalition
2093 Gottingen St.
Halifax, N.S. B3K 3B2

Barbara Blouin
N.S. Coalition for
Children & Youth
6940 Tupper Grove
Halifax, N.S. B3H 2M6

Feng Cai
Dept. of Anatomy & Neurobiology
Dalhousie University
Halifax, N.S. B3H 4H7

Debbie Castle
6294 Jubilee Road
Halifax, N.S. B3H 2G7

Carlos Coloma
Dept. of Anthropology
University of Montreal
P.O. Box 6128, Station A
Montreal, P.Q. H3C 3J7

Andrea Currie
5185 South Street, #8
Halifax, N.S. B3J 1A2

David Fletcher
6294 Jubilee Road
Halifax, N.S. B3H 2G7

Ron Fournier
R.R. #1
Glassville, N.B. E0J 1L0

Renaud Gallant
354 rue de la Montagne
N.D. du Portage, Que. G0L 1Y0

Caroline Hernandez
1657 Henry Street
Halifax, N.S. B3H 3K4

Jason Hofman
Citizens for Choice in Health Care
Box 7, Site 11, R.R.5
Armdale, N.S. B3L 4J5

Miriam Korn
22 Woodward Crescent
Halifax, N.S. B3M 1J7

Jacynthe Landry
354 rue de la Montagne
N.D. du Portage, P.Q. G0L 1Y0

Juanita Lechowick
30 Ferndale Drive
Sherwood, PEI C1A 6J3

Shirley Lyall
Labrador Inuit Health Commission
P.O. Box 234
Northwest River, Labrador A0P 1M0

M. Kay Matthews
Memorial University
School of Nursing
St. John's, Nfld. A1B 3V6

Lynn McIntyre
Faculty of Health Professions
Dalhousie University
Halifax, N.S. B3H 3J5

Sheila Morrison
6289 Yale Street
Halifax, N.S. B3L 1C9

Janet Murphy-Goodridge
53 Rennies Mill Road
St. John's, Nfld. A1C 3P9

Ravi Narayan, Coordinator
Community Health Cell
No.326, V Main, 1 Block
Koramangala
Bangalore 560 034, INDIA

Jane Oram
Health Promotion & Social
Development Office
Suite 1110, 5251 Duke Street
Halifax, N.S. B3J 1P4

Karen L. Parent
Primary Health Care Project
P.O. Box 129
Cheticamp, N.S. B0E 1H0

Marggi Pavlovski
3372 Connaught Ave.
Halifax, N.S. B3L 3B5

Fred Pender
Queen Margaret College
Edinburgh, AH12 8TS
Scotland

Judit Rajhathy
New Directions in Health
12 Richards Drive
Dartmouth, N.S. B3A 2P2

Marie Riley
Dept. of Public Relations
Mount St. Vincent University
Halifax, N.S. B3M 2J6

Linda Ross
St. John's OXFAM
Development Educator
St. John's, Nfld. A1C 6C2

Jeff Schelew
c/o Judit Rajhathy
New Directions in Health
12 Richards Drive
Dartmouth, N.S. B3A 2P2

Purnima Sen
Memorial University
School of Nursing
St. John's, Nfld. A1B 3V6

Qian Ping Tao
Dept. of Pharmacology
Dalhousie University
Halifax, N.S. B3H 4H7

gkisedtanamooqk
WABANAKI Cultural Resource
Centre
Box 127
Lagaceville, N.B. E0C 1K0

Frank Taussig
Bear & Co. Holistic Health Clinic
5871 Spring Garden Road
Halifax, N.S. B3H 1Y2

Norma Taussig
Bear & Co. Holistic Health Clinic
5871 Spring Garden Road
Halifax, N.S. B3H 1Y2

Colleen Cameron
Coady International Institute
St.Francis Xavier University
Antigonish, N.S. B2G 1C0

Karan Whiteman
2446 Creighton Street
Halifax, N.S. B3K 1S3

Sheila Zurbrigg
Dept. of History
Dalhousie University
Halifax, N.S. B3H 3J5

Nova Scotia
PWA Coalition

2095 Gottingen Street
Halifax, Nova Scotia
Canada B3K 3B2

Telephone 902-422-7622
Facsimile 902-422-2611

CSIH Atlantic Workshop
Advocating for Health - Building Coalitions: Moving ideas to Effective Action

Case Study
Nova Scotia Persons with AIDS Coalition
Black Outreach Project

In December 1990, Kim became employed with the Elizabeth Fry Society of Halifax/Dartmouth after desperately wanting to leave her present job at the time at Dalhousie Legal Aid Service. Kim's interest in wanting to work with women lead her to the job at E. Fry, but six months later she realized that her conflicting ideas concerning community development work with the Executive Director was a good enough reason for her to leave.

Within this six month period, Kim was not reluctant to let the Black community know that she was looking for employment elsewhere. Therefore, Kim would frequently get calls from people in the community informing her of different jobs available. It was also no secret to the Executive Director that she was planning to move on. In May 1991, Kim was graduating from the Maritime School of Social Work with a Bachelor of Social Work and had given a great deal of thought to wanting to work directly with the Black community.

So...one day as Kim was sitting at her desk in the Roy Building, she received a call from a friend telling her about a position available with the Nova Scotia Persons with AIDS Coalition. Kim immediately went to the store to grab a paper to review the ad. She knew then that this was the ideal job for her. In the month of May Kim was interviewed by the selection committee and was offered the job before her graduation.

Kim started with the NSPWAC Black Outreach Project on May 21, 1991. She spent the first few months doing orientation and reading. She talked extensively with the staff and volunteers involved with the Coalition to get an idea of what sort of education was done in the past on AIDS/HIV to the Black communities in Nova Scotia. After doing a little research, Kim was basically told that several attempts were made through the church and other means to provide AIDS Education to the Black community, but unfortunately all attempts were unsucessful.

The orientation phase of Kims work was over, but the reading continued. Kim was sort of lost with no direction so she called upon the expertise of her big sister. She told her sister that the Black outreach projects mandate is to provide culturally specific information, education and support services to the Black community in N.S. on AIDS/HIV. She also explained the goals of the project which is prevent the spread of HIV, provide culturally sensitive support, to advocate with and for those who are affected and infected in order to raise the profile and awareness of HIV as it affects the Black communities.

Kim and her sister talked about their perceptions of the Black community in N.S., how it works, dynamics, their experiences. They focused on how they think the Black community sees the issue of AIDS/HIV. They talked about the fact that the community has so many issues concerning racism etc they are grappling with, AIDS/HIV is at the bottom of the agenda. They both recognized that this was a problem because AIDS/HIV should be at the top of the agenda alongside racism. They also discussed some of the difficulties Black people have with associating themselves with AIDS/HIV.

The more Kim and her sister talked, the more Kim realized how much easier it was for her to conceptualize what she read on AIDS and how it affects the Black community. She was understanding how the Black race association with the origin of AIDS (AIDS started in Africa) had serious implications on providing AIDS Education to the Black community. Kim was feeling overwhelmed and wondered how one person could possibly effectively provide AIDS outreach to the Black community in N.S. in a two year period. Kim's sister helped her regain focus. She instructed Kim to develop a one year operational plan to direct her down the right path.

Kim developed a one year operational plan and was on her way. She knew she had lots of work ahead of her, but she had a positive attitude and outlook for the future. She knew her first initial step was to talk to the communities to find out what they needed to know at the same time raise the awareness of AIDS/HIV as it affects the Black community in N.S.

Kim spent the next year and 1/2 promoting the Black outreach project, doing speaking engagements and workshops on AIDS/HIV, dispeling myths and misconceptions on the origin of AIDS in Africa, working with existing Black organizatons in their efforts to fight AIDS/HIV, doing a needs assessment, networking with Black AIDS Service organizations across Canada and the U.S. and providing support and advocacy to Blacks affected and infected with AIDS/HIV.

One of the biggest issues in Kim's struggle to provide AIDS education i s the constant reminder of the views from workshop participants, media, researchers, health educators etc that AIDS originated in Africa. In January Kim was once again confronted with this problem. She arrived at work early one morning, grabbed a hot cup of earl grey and proceeded to her office. On her way, she decided to take a peak at the paper. There it was. The headlines read: **Nigerian Students angered by Red Cross Blood Refusal and Angry Africans protest against Red Cross Blood Donor Policy.** The Red Cross excludes donations from countries where rates of HIV infection are high. This is a policy two Nigerian students say is discriminatory.

Kim was angered by the two newspaper articles. She felt in soladarity with the Nigerian Students, but also felt like all her hard earned efforts of trying to educate the community on AIDS/HIV and its affect on the African N.S community was somehow ineffective. Kim felt hopeless and wondered how she should respond to what happened.

What suggestions would you give Kim in dealing with this dilemna? Do you see any solutions to this problem? What are Kim's options/alternatives available for dealing with the problem? How can the solution best be implemented?

LABRADOR INUIT HEALTH COMMISSION: MANAGEMENT OF NON-INSURED HEALTH BENEFITS

Shirley Lyall

This case study presents the process involved in establishing the Labrador Inuit Health Commission's ability to administer the Non-Insured Health Benefits Program (NIHB) to the Labrador Inuit through an agreement with Health and Welfare Canada. That ability is now threatened by the unilateral action of the government department.

The Labrador Inuit Health Commission, or LIHC, is the affiliate created by the Labrador Inuit Association (LIA) to deal with health issues. It was formed in 1985 and reports to the LIA Board of Directors. Funding comes from the Medical Services Branch (MSB) of Health and Welfare Canada. LIHC is very concerned with the issues of housing, meaningful employment, etc. and how they impact on the health of the Labrador Inuit. The workings of the health care delivery system are also of concern, but are only a small part of health.

The membership of LIA is spread out over most of Labrador and is centred in 5 very isolated communities. These communities are not accessible by road at any time of the year, air travel is limited to small aircraft, the use of airstrips only and travel by boat is limited to 4 months of the year.

LIHC chose to ask for administration of the NIHB program after successfully administering the Community Health Representative and

Interpreter programs. In February 1986, LIHC recommended to the management committee of the "Health Agreement" (representatives from Federal & Provincial Governments, LIA & Innu Nation) that the Labrador Inuit Association be funded directly to administer the Non-Insured Health Benefits for members of the Labrador Inuit Association. It wasn't until january 1989 that LIHC signed the first contribution agreement for NIHB's. Under this agreement the LIHC was to follow the national directives as given by Medical Services Branch in Ottawa.

Setting Up the Program

As part of the initial preparation, information and public relations campaigns were directed to service providers and the membership. Service providers include nurses at each station in each community, local pharmacies, doctors, physiotherapists, etc. Most are employees of Grenfell Regional Health Services, which is the primary health care provider in Labrador and is funded by the provincial government. The GRHS, pharmacies, taxi companies, private contractors, etc., were involved in setting up accounts for payment and provision of benefits.

MSB agreed to accept LIA's membership list as representing those eligible for health services. LIA and LIHC had to work together to update the list, computerize it, issue new membership cards and supply MSB with a list for entry into the National Status Verification System. It was arranged during the negotiations with MSB that benefits for members living in the province of

Newfoundland and Labrador would be billed to LIHC, and that members living in other provinces would access their benefits through their nearest MSB office. Unfortunately, MSB failed to inform the regional offices of this arrangement.

Partnerships

During this process, LIHC set up partnerships with other organizations. The St. John's Native Friendship Centre in St. John's is paid to help take care of patients once they reach St. John's. The referral clerk employed by LIHC co-ordinates patient accommodation, appointments, transportation, etc. Patients travelling from coastal nursing stations for health care go through Melville Hospital upon arrival and departure to Goose Bay. The referral clerk has been allowed by GRHS to operate out of the Melville Hospital in Goose Bay. This has created the opportunity for the referral clerk to work with the hospital staff in helping LIA members through the health care system.

LIHC met with the local optometrist so that the optometrist understood the LIHC program and so that LIHC understood the basics of medical jargon and diagnosis in relation to optometry.

An excellent example of partnerships formed is in the area of orthodontics. Through statistical reports compiled by LIHC, it was recognized that the number of people travelling outside of Labrador for orthodontic treatment was high and on the increase. These numbers were brought to the attention of MSB and GRHS, and everyone

worked together to get an orthodontist to visit the area on a regular basis. MSB provided some dollars to help in setting up an office for the orthodontist and in the recruitment of personnel. GRHS supplies the office space and support staff needed. LIA members are very happy to have this service in the area for a number of reasons: the amount of money being spent on medical transportation has now levelled off for this specialty, whereas it would have been on a steady increase; there was no-one from the northern coastal communities travelling to the island part of the province for this treatment until it was available in Goose Bay - now, people are travelling from coastal Labrador to Goose Bay regularly for this service.

The Agreement Unravels

LIHC and MSB negotiated guidelines which LIHC put into a Program Directory. The Program Directory was later used by MSB as a model to compile their own. At first, things worked out very well between LIHC and MSB, and the guidelines were followed as negotiated. As time went on, LIHC would get conflicting interpretations from MSB in Halifax and MSB in Ottawa when they had questions about the benefits. There are many "grey areas" in NIHB, and LIHC needed the advice of MSB. LIHC tended to stick by the law at first and make exceptions only with the advice of MSB. At first, there was "a" contact person for these "grey areas", but this person became a number of different people, and this advice was becoming more and more conflicting depending on who you contacted. Because of the conflicting interpretations coming from

the different MSB offices, LIHC asked for assistance less and less often and began making its own policy interpretations.

MSB has now come up with a scheme to contract Blue Cross to administer all benefits for all native people in Canada including LIHC. LIHC had asked from the very beginning to be excluded from this plan. This was first talked about approximately 2 to 3 years ago, but nothing was said until this year. Blue Cross is to start administering the drugs portion of NIHB on March 1st, 1993. LIHC was not informed of a decision as to whether or not it was included in this plan until many phone calls later, when finally, on February 5th, Ottawa told it that the LIHC can continue to administer the drugs as long as it gives them what they require in regards to statistics (they still don't know what they require). The LIHC was told not to mention this decision to the Halifax office, as they were not yet aware of this decision. In the meantime, the LIHC is waiting to hear from the regional office for details of the statistical requirements and for updates of the drug formulary which must now be followed to a 'T'.

The LIHC believes that MSB is still planning to eventually have Blue Cross administer all Non-Insured Health Benefits including glasses, medical and surgical supplies, orthotics, etc. for all native people in Canada. What can the LIHC do to maintain its partnerships and its people's program?

CASE STUDY:

SO YOUR N.G.O. WANTS TO DO ADVOCACY?

Dr. Lynn McIntyre

The Organization is a national association and non-governmental organization (NGO) with 750 members across Canada. It has evolved from a program that supported student experiences overseas into a still fledgling organization "dedicated to making an active contribution to the evolving global understanding of health in development". Its mission includes international health advocacy and one of its goals is "to advocate recognition of the importance of health in development activities among Canadian policy makers, the public and health-related personnel, and influence Canadian policies in this direction".

The Organization operates with a small staff who have limited public relations expertise and who are very busy running day-to-day operations in the Ottawa-based office. The Organization is governed by a volunteer Board and has recently created three standing committees chaired by Board members: education, advocacy, and communications. The Organization has supported educational workshops in the past and this may become a focus of the newly-formed education committee. The communications committee will likely oversee the long-established Organization newsletter. The Organization has little history of advocacy work but "wants to get into it", hence the advocacy committee's *raison*

d'être. A sum of $2000 is set aside for the 'advocacy committee' in this new fiscal year.

The Organization has loose and informal relations with other development organizations through the Canadian Council on International Cooperation. It has established some early contacts with government officials at the Canadian International Development Agency (CIDA) and has once spoken before a federal-provincial committee on international affairs. The members of the Organization are largely health-related professionals with some academic members and some broadly based, non-health professional membership.

At a recent Board meeting, the priority activity identified for advocacy was the development of an advocacy strategy and guidelines. The Chairs of the three committees have been given a list of 12 names of members from across Canada who are "interested in committee work with the Organization". Some of the Board members are also interested in advocacy.

The Executive Director of the Organization thinks that it's time to "get going" in advocacy.

You are the Chair of the Advocacy Committee. You do not live in Ottawa. You do not have a lot of free time. You are not an expert lobbyist or an expert in the area. What will you do?

THE CUETZALAN EXPERIENCE

Carlos Coloma

The Mexican National Indigenous Institute (traditionally dedicated to ethnographic research and activities to support and develop indigenous cultures) took charge of a hospital located in the city of Cuetzalan in the Sierra of Puebla.

This hospital was totally abandoned and had no resources to support the implementation of the different programs of the Ministry of Health. The Institute took a series of administrative and technical measures that contributed to the establishment and experimentation of an alternative within existing health policies. Amongst them were the following:

- Hospital authorities interested in working with indigenous populations were appointed. The sub-director was an agronomist.
- Regional radius of work was established. Taking the hospital as a base, activities were developed in 6 health centres within the SILOS (Sistema Local de Salud, or Local Health System) proposal.
- An agreement was reached with the regional organization of healers to take part in health activities.
- Hospital facilities were altered to enable healers to carry out their therapeutic rituals.
- Medicinal plants were planted on hospital grounds to allow for the preparation of basic remedies (expectorant, dermal remedy against diarrhea, etc.).

The immediate impact of the experience showed that the indigenous population started to go to the hospital for consult visits to both

the doctor and the healer, and in a few months these increased significantly.

With this sequence of events, it was possible to develop preventive and curative programs such as that for tuberculosis control. Following the diagnosis by a doctor, the cure is carried out by the healer who delivers both the therapeutic scheme based on western medicine, and the rituals of indigenous traditional healing.

A participative study was carried out within the communities to detect cases of trachoma. While it was thought to be a limited problem it was observed that, in actual fact, it affected thousands of people.

After the first year of experience, the Ministry of Health asked the Institute to take charge of 5 other hospitals located in different regions of the country. An inter-institutional effort was carried out simultaneously by the Institute, MOH and the Institute of Social Insurance) to support the organizations of healers in their development.

To date, governmental recognition of healers has been achieved and may have adopted the name of traditional doctors while requesting a revision of the Health Code to legalize their work.

In addition, the National Organization of Traditional Doctors requested a revision of medical school curricula (introduction to traditional medicine, role of healers, etc.) while at the same time asking for adequate training for them on the main, western

diseases.

Up to now, it is possible to observe the achievement of goals (expected and unexpected) through an unconventional process in public health (participatory strategies with the healers, institutional support - both formal and informal, consensus at a personal level, short-term planning following an intervention, etc.); but, most importantly, a series of problems emerge, such as:

- Is it possible to combine Western Medicine with Traditional Indigenous Medicine?

- What is the soundness of the agreements between institutions and communities to sustain a long-term process?

- How can one make health concepts stemming from different scientific traditions compatible?

- To what degree can professional organizations, especially medical ones, facilitate this process?

- How are new criteria going to be established to determine improvement (or not) in the health of populations, and assess the impact of traditional medicine?

- To what degree will the "institutionalization" or extension of the experience consolidate a valid alternative or a replicable model?

UNDERSTANDING CULTURE
A Basis for Coalition Building

Purnima Sen

Background:

During the 80's, Carib, a tiny country of 190,000 people, requested help to meet a crisis situation of drug and alcohol abuse with no trained personnel in mental health and psychiatric services. The challenge was met by a three-year project funded by CIDA to train health personnel to meet Carib's needs and to make it self-sufficient.

According to the Carib government's wish, all training programs under the project were planned to be offered within the country, and the partner institution identified was Carib School of Nursing, one of the few post-secondary institutions in Carib.

Carib School of Nursing was a government institution, hence had to abide by the government protocol and bureaucracy. The Director of the School was the designated counterpart for the CIDA project, but her activities and decision-making abilities were guided by the health department policies and protocol.

Ela, a specialist in mental health/psychiatric nursing, was hired on a one-year contract (renewable) for teaching in Carib. Ela visited the country the previous year before accepting the job, and also had a briefing in Ottawa. CIDA funds provided her salary and accommodation, and the vehicle purchased for the project was also

available for her personal use. Communication channel was the co-Director of the project (project counterpart) for all administrative affairs and student problems, and the project Director for academic and project-related problems. Communication with the Director was maintained through phone, fax and the Director's periodic visits to Carib.

Crisis in Coalition Building:

The first year of the project created much enthusiasm among many sectors in the country, and the Minister of Health was a strong supporter of the project. One of the unintended benefits was the planning of First National Congress on Mental Health in Carib. In spite of the success experienced, Ela did not renew her contract and antagonized many people with her derogatory comments about the country and its systems.

Bonnie, the second cooperant, accepted the challenge to work in Carib and had a similar briefing and orientation as Ela had. Moreover, Bonnie met Ela for first-hand information about the country and the program. Bonnie had one month to prepare for the next group of students, and around this time the Mental Health Congress was about to be launched. The graduates of the first program actively participated and the Congress sessions were held in different parts of the country.

Bonnie found that the CIDA Project vehicle was booked for the

Congress without her prior knowledge and approval. She perceived this as a violation of the CIDA agreement and her rights. She refused the use of the vehicle for such purposes. The Deputy Minister of Health tried to persuade her to no avail, needless to say, he took it as an arrogant behaviour and personal insult. The crisis came to a peak when Bonnie removed the licence plate of the vehicle, drove the vehicle to her residence and the Deputy Minister threatened to deport her.

BUILDING COALITIONS TO IMPROVE MATERNAL HEALTH IN SOUTH-EAST NIGERIA

M. Kay Matthews

A joint Nigerian-Canadian project is underway to lower the extremely high maternal mortality/morbidity rates in an area in South-East Nigeria. One arm of the project is to train traditional birth attendants to recognize high-risk complications in pregnancy and labour, and to transfer the mothers to regional maternity centres. A major issue is to get the co-operation of the TBA's to participate in the program and to get the mothers to agree to transfer to the maternity centres. The centres have qualified midwives, but the facilities are very poor, e.g., there is no running water, electricity or other essentials for effective care of mothers with complications.

Community support is essential for the success of the program. Early in the project planning, an approach was made to the community leaders who are responsible for the maternity centres. The community leaders promised that they would be responsible for seeing that the centres would be upgraded and equipped to handle emergencies. However, when the project was ready to start, we found that nothing had been done to upgrade the facilities and that the maternity centre midwives had not been paid for three months. Morale among them was very low and the success of the project has been jeopardized.

How can the coalitions be strengthened to improve this situation? How might we advocate for the mothers and the midwives?

THE CASE OF LEONARD PELTIER

gkisedtanamooqk

The issue of the continuing legacy of historic injustice to Indigenous People is the story of Leonard Peltier. Set in the classical frontier of American wild west is the ceaseless confrontation of American adventurists versus the fight of American Indians to maintain their cultural context. The deaths of two FBI agents provides the impetus for the American jurisprudence to fail Leonard Peltier. Government acknowledgement to the undetermined account of the agents' deaths, manufacturing evidence to achieve conviction, knowingly withholding evidence crucial to [proving] Peltier's innocence, intentionally falsifying evidence for the purpose of extradition, the use of force and coercion in the intimidation of witnesses, all contribute to the denial of a fair trial and freedom for Leonard Peltier.

The problem questions the integrity of both the Canadian and American systems of justice (or "just-us") in the adversarial role against Indigenous fight for fundamental liberation from colonial tyranny. Can western civilization, founding a system of the rule of Law and Order, propagandizing equality and justice, withstand the pressures of its own justices, government agents, and politicians to achieve convictions at the cost of guaranteed human and civil constitutional rights?

A 90 minute film docu-drama, entitled INCIDENT AT OGLALA, by Robert Redford, will highlight this case study.